

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
11428											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <i>Mary</i> First <i>ARMSTRONG</i> Middle Last						2a. DATE OF DEATH Month <i>8</i> Day <i>29</i> Year <i>68</i>			2b. HOUR <i>6:25</i> P.M.		
3. SEX <i>Female</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH <i>06-25-97</i>		6. AGE (In years last birthday) <i>71</i> YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>MD.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Dorchester</i> Md.					
10. CITY OR TOWN OF DEATH <i>Rural-Cambridge</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Eastern Shore State Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>UNKNOWN - Retired.</i>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD.</i>		13b. COUNTY <i>Caroline</i>		13c. CITY OR TOWN <i>Ridgely</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>NONE</i>			
14. FATHER'S NAME First <i>Ernest</i> Middle <i>Armstrong</i> Last				15. MOTHER'S MAIDEN NAME First <i>Julia</i> Middle <i>Wilkinson</i> Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <i>UNKNOWN</i>		17. INFORMANT <i>Med. Records, Eastern Shore State Hospital</i> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CORONARY OCCLUSION</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>HYPERTENSIVE CARDIOVASCULAR DISEASE</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 HOUR.</i> <i>SEVERAL YEARS</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (H) (this hospital) attended the deceased from <i>MAY 6</i> , 19 <i>68</i> , to <i>AUG. 29</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>AUG. 29</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Miguel A. de la Guardia, M.D.</i> DEGREE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>8/29/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>MIGUEL A. de la GUARDIA M.D.</i>		22e. ADDRESS <i>E.S.S. 4.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9-2-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Union</i>		23d. LOCATION (City or Town) (County) (State) <i>Goldsboro, Md.</i>					
24. FUNERAL DIRECTOR <i>J. E. Boulaire</i>				ADDRESS <i>Goldsboro, Md.</i>		25a. REC'D BY REGISTRAR <i>SEP 3 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

11-28

11-28

11-28



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH 11429 Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000																					
1. DECEASED-NAME (Type or Print) <b>Reginald P. Gilbert Bailey Jr. Sr.</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>8/</b> Day <b>27</b> Year <b>1968</b> 2b. HOUR <b>11:20</b> P M											
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>5/3/1938</b>		6. AGE (In years last birthday) <b>30</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>		2c. DATE PRONOUNCED DEAD Month <b>8</b> Day <b>27</b> Year <b>1968</b> 2d. HOUR <b>11:20</b> P M									
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>Dorchester</b> Md.									
10. CITY OR TOWN OF DEATH <b>Cambridge</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>527 Cedar St.</b>								12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Barbar</b>				12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>				13b. COUNTY <b>Dorchester</b>				13c. CITY OR TOWN <b>Cambridge</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER <b>527 Cedar St.</b>					
14. FATHER'S NAME First <b>Russell</b> Middle <b>Ross</b> Last <b>Bailey Sr.</b>						15. MOTHER'S MAIDEN NAME First <b>Blanche</b> Middle <b>Elizabeth</b> Last <b>Jackson</b>															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>Korean</b>				17. INFORMANT ADDRESS <b>218-34-8066 Gloria Bailey 527 Cedar St. Camb. Md.</b>													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Grand mal Epilepsy</b> <b>345.1</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>353.1</b>																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year <b>19</b> HOURS A.M. <b></b> P.M. <b></b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE <b>John Mace Jr.</b>				EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>9/1/68</b>									
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) <b>Cambridge, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>9/1/68</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Cambridge, Dor. Md.</b>									
24. FUNERAL DIRECTOR ADDRESS <b>St. Clair Funeral Est. Cambridge, Md.</b>								25a. REC'D BY REGISTRAR <b>SEP 9 1968</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									

ESATE

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 18. PM3. Page 5 may be retained for your files.

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11430

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11438

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Charles F. BANNING						Month Day Year			8 7 1968		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR
male	white	10-06-75	92 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year			2 35
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			X Md		
Maryland		U.S.A					Dorchester				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cambridge (Rural)			Eastern Shore State Hosp.			Carpenter, workman			-		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Talbot		Easton				Route #1, Box 105		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
James A BANNING			Tyler, Mary Ann BANNING								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
no			Not listed			Eastern Shore State Hosp. Cambridge, Md.			Med Records		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Terminal Pneumonia										3 days	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) Chronic Bronchitis										3 days	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
9047											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		7 AM. 8/14/1968		Fall in hospital							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
		Hospital		Cambridge, Md. Ver.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED	
John Mace Jr.		JOHN MACE JR.		M.D.				ADDRESS (Street, city, town, or county)		8/17/68	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		8/19/1968		SPRING HILL		EASTON, MD					
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Maurice E. Neumann-Jr.				DATE AUG 8 1968				Charles Judge			



11130

James A. Gunning

Married 10-02-92

Married 10-02-92

Married 10-02-92

Married 10-02-92

Married 10-02-92

Married 10-02-92

Married 10-02-92

Married 10-02-92

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VR A13 (4)  
30M REV. 7-68

11431		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				11439				
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>WILLIAM CATHROP CHAMBERS</b>			First Middle Last			2a. DATE OF DEATH Month <b>8</b> Day <b>17</b> Year <b>68</b>		2b. HOUR P <b>7:25 M</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>April 4, 1894</b> <del>DAKOTA</del>		6. AGE (In years last birthday) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b> <b>UNKNOWN</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>DORCHESTER</b> Md.				
10. CITY OR TOWN OF DEATH <b>CAMBRIDGE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>EASTERN SHORE STATE HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>			
13a. USUAL RESIDENCE (Where deceased admission) STATE <b>Mo.</b>		13b. COUNTY <b>CAROLINE</b>		13c. CITY OR TOWN <b>PRESTON</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RFD #2</b>		
14. FATHER'S NAME <b>BASCOM NICHOLSON CHAMBERS</b>			First Middle Last			15. MOTHER'S MAIDEN NAME <b>MARY IDA TODD</b>			First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service) <b>UNKNOWN No</b>			16b. SOCIAL SECURITY NO. <b>212-56-1195</b>		17. INFORMANT <b>RECORDS OF THE EASTERN SHORE STATE HOSPITAL</b>				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumopneumonia</b> <b>4369</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>C.V.A. RT. side</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized atherosclerosis</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>331x chronic pyelonephritis</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>undeter.</b> <b>undeter.</b>		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>8/10/1968</b> , to <b>8/17/1968</b> , that (I) (we) lost saw the deceased alive on <b>8/17/1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>FARUK OZER</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>8/17/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>FARUK OZER</b>				22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Aug. 21, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Junior Order Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Preston, Maryland</b>				
24. FUNERAL DIRECTOR <b>from Preston, Jr. Frederickburg, Maryland</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>AUG 22 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11432

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11440

1. DECEASED-NAME (Type or Print)			First John			Middle Wesley			Last Chester			20. DATE KNOWN OF DEATH Month Day Year 8-30 1968			24. HOUR 11:4 P.M.		
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 2/12/1909		6. AGE (In years last birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		21. DATE PRONOUNCED DEAD Month Day Year 8 30 1968			24. HOUR 11:4 P.M.		
7a. BIRTHPLACE (State or foreign country) Md.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. COUNTY OF DEATH Dorchester Md.					
10. CITY OR TOWN OF DEATH Church Creek				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Rt. 335				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer				12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Dor.				13c. CITY OR TOWN Church Creek				13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First Middle Last Robert James Chester						15. MOTHER'S MAIDEN NAME First Middle Last Nettie Keene											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. 216-07-3152		17. INFORMANT ADDRESS Edmund Chester Church Creek, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries, severe 814.7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 812.4																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 10:30 A.M. 8/30/68				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Was hit by a car.									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Highway				21f. LOCATION Street or R.F.D. No. City or Town County State St. Rt. 335 nr. Church Creek, Dor. Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE John Mace Jr.				EXAMINER'S NAME (Type) John Mace Jr. M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED 9/4/68 Cambridge, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 9/3/68		23c. NAME OF CEMETERY OR CREMATORY Old Field Cemetery				23d. LOCATION (City or Town) (County) (State) Church Creek, Dor. Md.							
24. FUNERAL DIRECTOR St. Clair Funeral Est. Cambridge, Md.				25a. REC'D BY REGISTRAR SEP 9 1968				25b. REGISTRAR'S SIGNATURE Charles Judge									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																		
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																		
CERTIFICATE OF DEATH																		
1. DECEASED NAME (Type or print)			First <b>NELLIE</b>			Middle <b>W.</b>			Last <b>CHRISTOPHER</b>			2a. DATE OF DEATH Month <b>Aug.</b> Day <b>24</b> Year <b>1968</b>			2b. HOUR <b>M</b>			
3 SEX <b>Female</b>			4 RACE <b>White</b>			5. DATE OF BIRTH <b>March 7, 1886</b>			6 AGE (In years last birthday) <b>82</b> YRS			IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>			IF UNDER 24 HRS HOURS <b></b> MIN <b></b>			
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>Dorchester</b>									
10. CITY OR TOWN OF DEATH <b>Cambridge</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Cambridge Md. Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>School teacher-Ret.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Teaching</b>									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Dorchester</b>			13c. CITY OR TOWN <b>Cambridge</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>212 Maryland Avenue</b>						
14. FATHER'S NAME First <b>Thomas</b>			Middle <b>?</b>			Last <b>Christopher</b>			15. MOTHER'S MAIDEN NAME First <b>Fannie</b>			Middle <b>?</b>			Last <b>Tuttle</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>---</b>			17. INFORMANT Address <b>LeCompte Funeral Service records</b>												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>4107</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>10 yrs</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)												
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State												
22a. I certify that (I) (this hospital) attended the deceased from <b>8/15/68</b> , 19 <b>68</b> , to <b>8/24/68</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>8/24/68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <b>Lawrence Maryanov MD</b>			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>8/26/68</b>									
22d. PHYSICIAN'S NAME (Type) <b>Lawrence Maryanov</b>			22e. ADDRESS <b>610 Race St Cambridge, Md</b>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Aug 27, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Cambridge Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Cambridge, Maryland</b>									
24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>			ADDRESS			25a. REC'D BY REGISTRAR <b>AUG 28 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									

MEDICAL CERTIFICATION



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		2b HOUR
Helen Josephine Conway								Month 8 Day 22 Year 1968	10:30	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD	2d HOUR	
Female	Negro	1/7/1923	45 YRS					Month 8 Day 22 Year 1968	10:30	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH						
Md.	USA			Dorchester						
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Cambridge	Cambridge Md. Hosp.		Laborer		Factory					
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE	13b. COUNTY	13c CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER						
Md.	Dor.	Cambridge	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	414 Charles St.						
14 FATHER'S NAME	First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last		
James		H. Chester		Viola E. Conway						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No	215-16-3641		Viola Rhodes		414 Charles St. Cambridge, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									Instant	
IMMEDIATE CAUSE (a) <del>COXONEXXXXXX</del> Cardiac arrest										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost										
(b) Coronary occlusion										
DUE TO, OR AS A CONSEQUENCE OF										
(c) Following GYN surgery										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
X										
19a. DATE OF OPERATION			9b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 ALTOPSY?			
8/22/68			Leiomyomata uteri				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			HOUR A.M. P.M. 19							
2d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		2f LOCATION Street or RFD No		City or Town		County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		John Mace Jr. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type)				ADDRESS (Street, city, town, or county)		Cambridge, Md.		22b. DATE SIGNED 9/4/68		
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)	(State)	
Burial		8/25/68		Cordtown Cemetery		Cambridge, Dor.			Md.	
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
St. Clair Funeral Est.				Cambridge, Md.		DATE SEP 9 1968		J. Charles Judge		

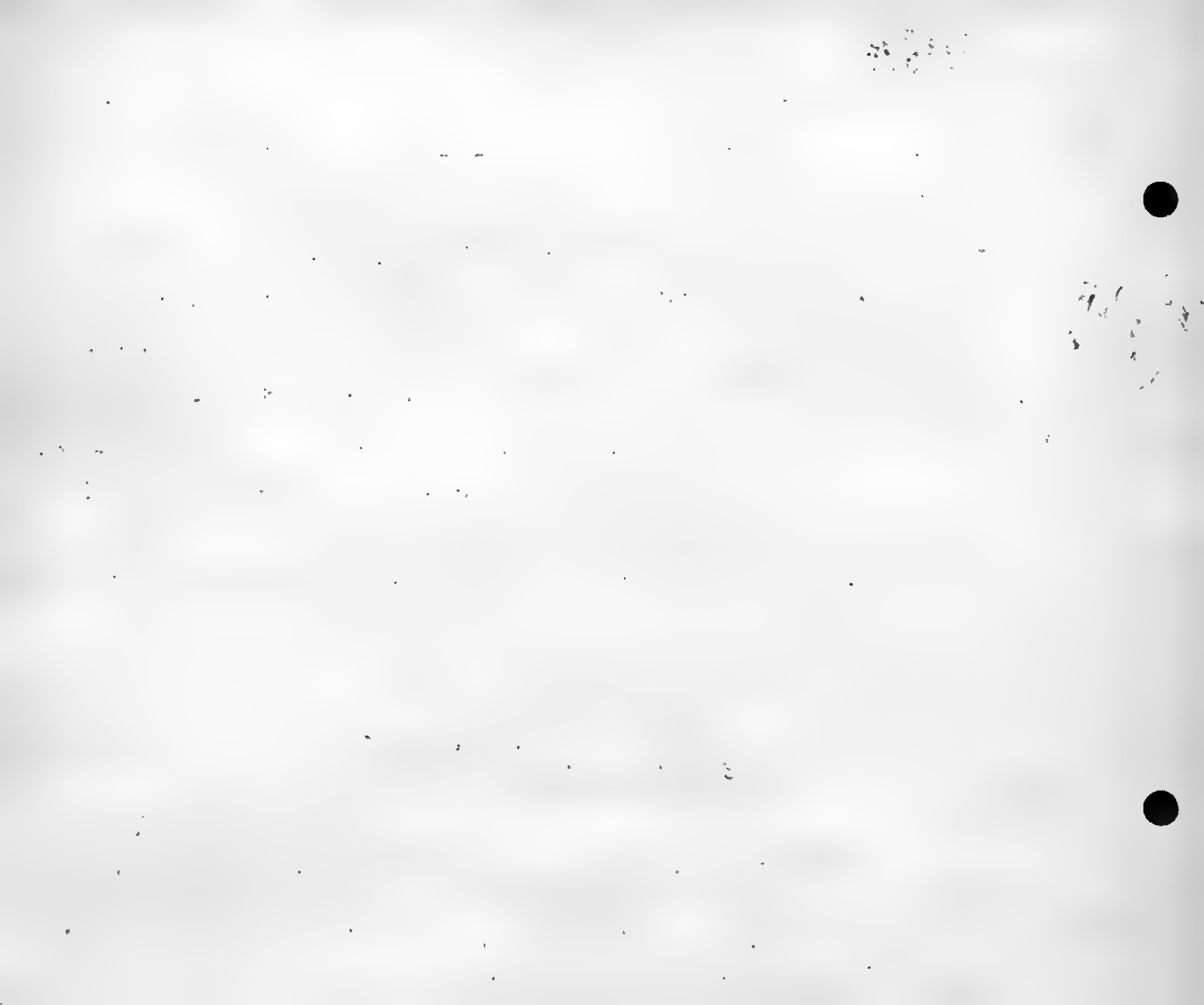




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please retain the other papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

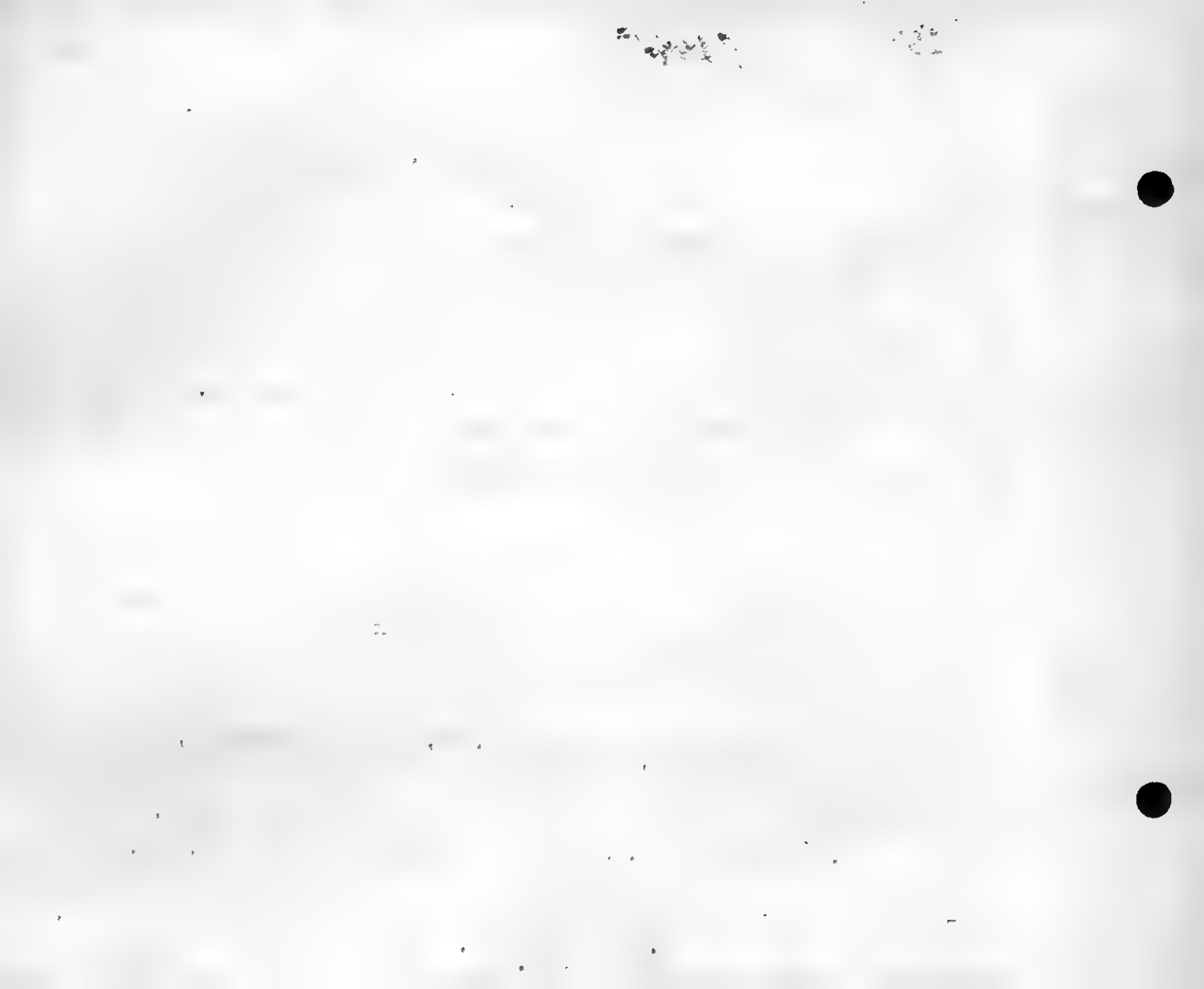
MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
11436 CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
BESSIE			COPPER			Month 8 Day 17 Year 68		5:10 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
FEMALE		NEGRO		09-04-97		71 70 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND		USA				DORCHESTER				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
CAMBRIDGE			EASTERN SHORE STATE HOSP.			Housewife		None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MD.			TALBOT		EASTON		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RT#1 Box 156	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
SAMUEL			COPPER			FANNIE JENKINS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO. (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
			214 32 2415		RECORDS OF THE EASTERN SHORE STATE HOSPITAL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonitis</u>									one week	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary emphysema and fibrosis</u>									undetermined	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic pyelonephritis</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Generalized atherosclerosis, Atherosclerotic, hypertensive heart disease</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>2/4/1966</u> , to <u>8/17/1968</u> , that (I) (we) last saw the deceased alive on <u>8/17/1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE <u>Faruk Ozer</u>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>8.17.68</u>				
22d. PHYSICIAN'S NAME (Type) <u>FARUK OZER M.D.</u>				22e. ADDRESS <u>EASTERN SHORE STATE HOSPITAL</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		8/22/68		Unionville		Unionville Talbot Md.				
24. FUNERAL DIRECTOR		426 DOWNSIDE ST. EASTON		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
<u>Dashiell Funeral Home</u>				DATE <u>AUG 27 1968</u>		<u>Charles Judge</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of Pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
11436 CERTIFICATE OF DEATH 11444									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
LOUISE DAVIS COSTON						AUGUST 28, 1968			8:00 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
FEMALE		NEGROID		APRIL 6, 1906		62 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.
VIRGINIA		USA				DORCHESTER			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work-a-life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
CAMBRIDGE			423 CHARLES STREET			LABORER			
13a. USUAL RESIDENCE (Where deceased lived, if institut an. Residence before admission)			13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
MARYLAND			DORCHESTER		CAMBRIDGE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		423 CHARLES STREET
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			
CALVIN DAVIS						JANET DAVIS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address
NO						JANET LAND			423 CHARLES ST. 21613
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY. Cardiac Decompensation									
IMMEDIATE CAUSE (a) 41 x 4 DUE TO, OR AS A CONSEQUENCE OF Coronary heart disease									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No		City or Town County State	
22a. I certify that ( ) (this hospital attended the deceased from Sept. 26, 1967, to August 28, 1968, that (I) (we) last saw the deceased on August 28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						22c. DATE SIGNED			
J. EWIN FASSETT, M.D.						Aug. 31, 1968			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
						623 HIGH STREET, CAMB., MD.			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
REB-BURIAL		9/2/68		CALVERT		NORFOLK VIR.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Frederick C. Delia		SEP 9 1968		Charles Judge					
ST. CLAIR FUNERAL H. CAMBRIDGE, MD.									





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11437

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)		First ANNA	Middle KATHLEEN	Last CUNNINGHAM	2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year Aug 30 1968	2b HOUR M
3 SEX Female	4 RACE White	5 DATE OF BIRTH Nov 8 1916	6 AGE (in years last birthday) 51 YRS	7 UNDER YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year 19 M
7a BIRTHPLACE (State or foreign country) Penna		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Dorchester Md	
10 CITY OR TOWN OF DEATH Cambridge		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY Home
13a USUAL RESIDENCE (Where deceased lived if institution residence before admission) STATE Maryland		13b COUNTY BALTO.	13c CITY OR TOWN Catonsville	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 315 Newburg Avenue	
14 FATHER'S NAME First Middle Last Aloysius Kaylor			15 MOTHER'S MAIDEN NAME First Middle Last Ann Sponski			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO (If yes give war or dates of service) 212-36-2474		17 INFORMANT ADDRESS Mr. Regis Cunningham, Catonsville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypoglycemia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Overdose insulin</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>270x Coronary heart disease</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hours
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State		
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>						
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John W. Pace Jr.			22b. DATE SIGNED 8/30/68	
23a BURIAL-CREMATATION REMOVAL (Specify)		23b DATE 9-4-68	23c NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		23d LOCATION (City or Town) (County) (State) Woodlawn Ind	
24. FUNERAL DIRECTOR ADDRESS LeCompte Funeral Service, Cambridge, Maryland				25a RECD BY REGISTRAR SEP 5 1968	25b REGISTRAR'S SIGNATURE J Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11430

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1146

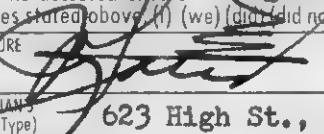
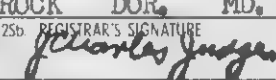
1. DECEASED-NAME (Type or print) Lyda Evelyn Dean			2a. DATE OF DEATH Month Day Year August 7 1968		2b. HOUR 230 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH March 7, 1891		6. AGE (In years last birthday) 77 YRS.	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester Md.	
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge-Md. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk department store		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm-ssion) STATE Md.		13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 301 West End Ave.
14. FATHER'S NAME First Middle Last Thomas Andrews		15. MOTHER'S MAIDEN NAME First Middle Last Kate Stewart			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO (If yes give year or dates of service) 214-07-7208		17. INFORMANT Address Mrs. Earl Bennett Cambridge Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> 43-9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 62 DAYS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 6/13/68 to 8/7/68, that (I) (we) last saw the deceased alive on 8/7/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W. E. GUNBY JR. M.D.				22c. DATE SIGNED 8/8/68	
22d. PHYSICIAN'S NAME (Type) W. E. GUNBY JR. M.D.				22e. ADDRESS CAMBRIDGE MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE August 9, 1968		23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park	
24. FUNERAL DIRECTOR Kenneth R. Thorne Jr.		ADDRESS Cambridge Md.		25a. REC'D BY REGISTRAR DATE AUG 14 1968	
				25b. REGISTRAR'S SIGNATURE Charles J. J. J.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13  
30M REV 1-68

11434										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										11447									
1. DECEASED-NAME (Type or print) First Middle Last <b>ROY ELMER ENNELS</b>										2a. DATE OF DEATH Month Day Year <b>AUGUST 11, 1968</b>										2b. HOUR <b>7:45a M</b>									
3. SEX <b>MALE</b>					4. RACE <b>NEGROID</b>					5. DATE OF BIRTH <b>JULY 25, 1905</b>					6. AGE (In years last birthday) <b>63</b> YRS.					IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN									
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>					7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <b>DORCHESTER</b> Md.														
10. CITY OR TOWN OF DEATH <b>CAMBRIDGE</b>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CAMBRIDGE MD. HOSP., INC.</b>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>LABORER</b>					12b. KIND OF BUSINESS OR INDUSTRY <b>FOOD PACKING</b>														
13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>					13b. CO. CITY <b>DORCHESTER</b>					13c. CITY OR TOWN <b>CHRIST ROCK</b>					13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER <b>RT. #1 BOX 34</b>									
14. FATHER'S NAME First Middle Last <b>GEORGE P. ENNELS</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>MINNIE BANKS</b>					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (if yes give year or dates of service) <b>NO</b>										16b. SOCIAL SECURITY NO <b>220-14-1978</b>					17. INFORMANT Address <b>ESTELLA ENNELS RT 1 BOX 34 21613</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Ruptured abdominal aortic aneurysm</b> <b>441.2</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4012</b>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No City or Town County State																			
22a. I certify that ( ) (this hospital) attended the deceased from <b>Sept. 16, 1967</b> to <b>Aug. 11, 1968</b> , that (I) (we) lost saw the deceased alive on <b>August 11, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE 										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <b>Aug. 12, '68</b>														
22d. PHYSICIAN'S NAME (Type) <b>623 High St., Camb., Md.</b>										22e. ADDRESS <b>J. EDWIN FASSETT, M.D.</b>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>					23b. DATE <b>8/14/68</b>					23c. NAME OF CEMETERY OR CREMATORY <b>CHRIST ROCK</b>					23d. LOCATION (City or Town) (County) (State) <b>CHRIST ROCK DOR. MD.</b>														
24. FUNERAL DIRECTOR <b>Fredrick C. Delain</b>										ST. CHAIR FUNERAL H. CAMBRIDGE, MD.					25a. REGD. BY REGISTRAR <b>AUG 16 1968</b>					25b. REGISTRAR'S SIGNATURE 									

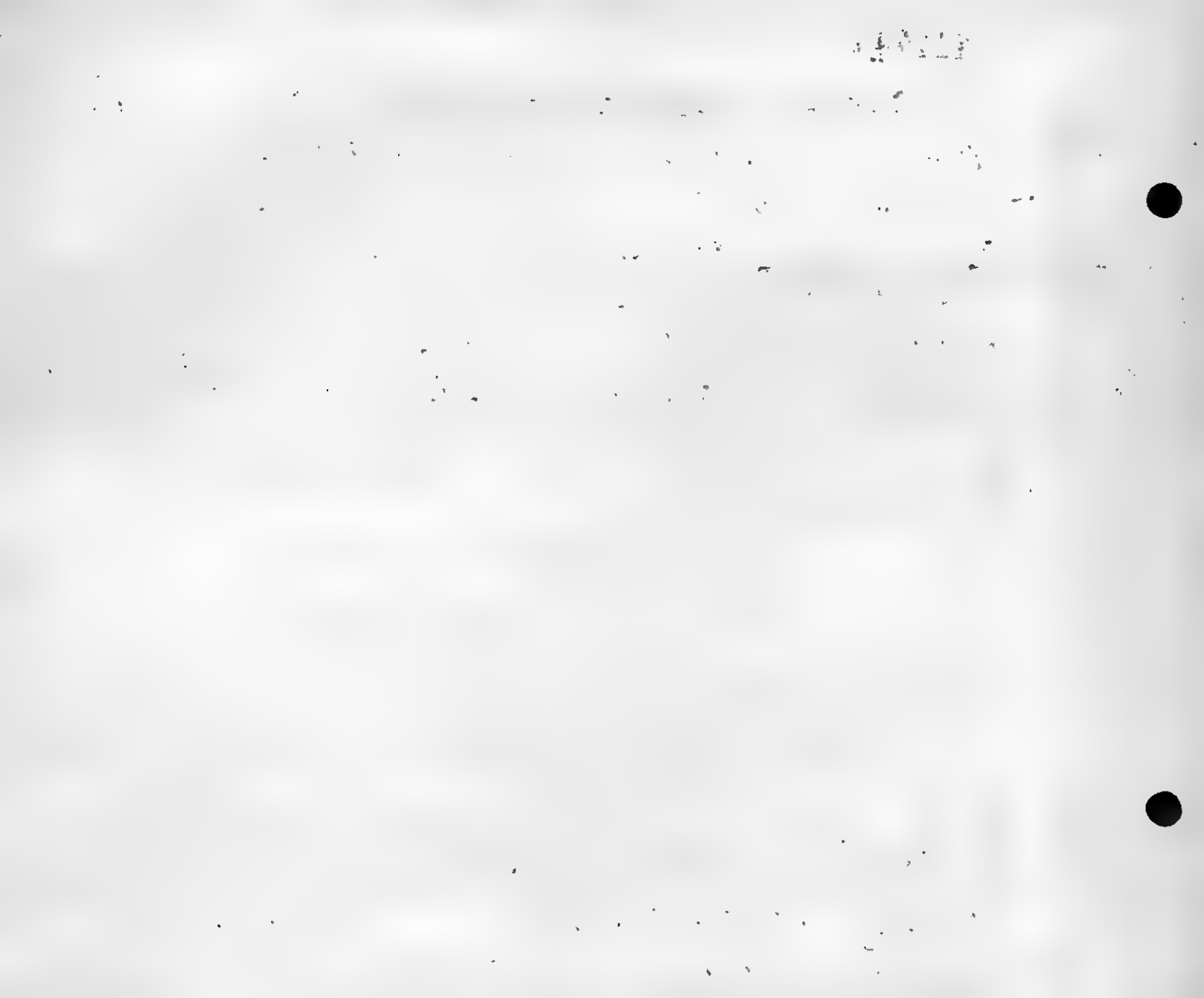




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the funeral director. Pages 1 and 2 should be filed with the State Dept. at Baltimore prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) <b>CLEOPHUS FREDERICK ESKRIDGE</b>						2a. DATE OF DEATH <b>8</b> Month <b>16</b> Day <b>1968</b>		2b. HOUR <b>M</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>JULY 14, 1901</b>		6. AGE (in years last birthday) <b>67</b> YRS		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>DORCHESTER</b> Md.					
10. CITY OR TOWN OF DEATH <b>BALESTOWN</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>RFD3 SEAFORD, DEL</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>FARMER</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>DORCHESTER</b>		13c. CITY OR TOWN <b>BALESTOWN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RFD3 SEAFORD, DEL</b>			
14. FATHER'S NAME First <b>ARTHUR</b> Middle <b>D</b> Last <b>ESKRIDGE</b>				15. MOTHER'S MAIDEN NAME First <b>FLORENCE</b> Middle <b>W</b> Last <b>WHEATLEY</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO <b>221-10-9514</b>		17. INFORMANT <b>HAROLD F. ESKRIDGE, RFD3 SEAFORD, DEL</b> Address <b>BALESTOWN</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Lung</b> <b>1984</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>adenocarcinoma bladder</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>nyko</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1810</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 6, 1966</b> , to <b>Aug, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 19, 68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John T. Burkley, M.D.</b> DEGREE <b>M.D.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>8-20-68</b>					
22d. PHYSICIAN'S NAME (Type) <b>John T. Burkley, M.D.</b>		22e. ADDRESS <b>Pine Bluff Rd, Salisbury, MD</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>8/19/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FIREMEN'S</b>				23d. LOCATION (City or Town) (County) (State) <b>SHARPTOWN, MD</b>			
24. FUNERAL DIRECTOR <b>NEWNAM FUNERAL HOME, SHARPTOWN, MD</b> ADDRESS				25a. REC'D BY REGISTRAR <b>AUG 23 1968</b> DATE		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



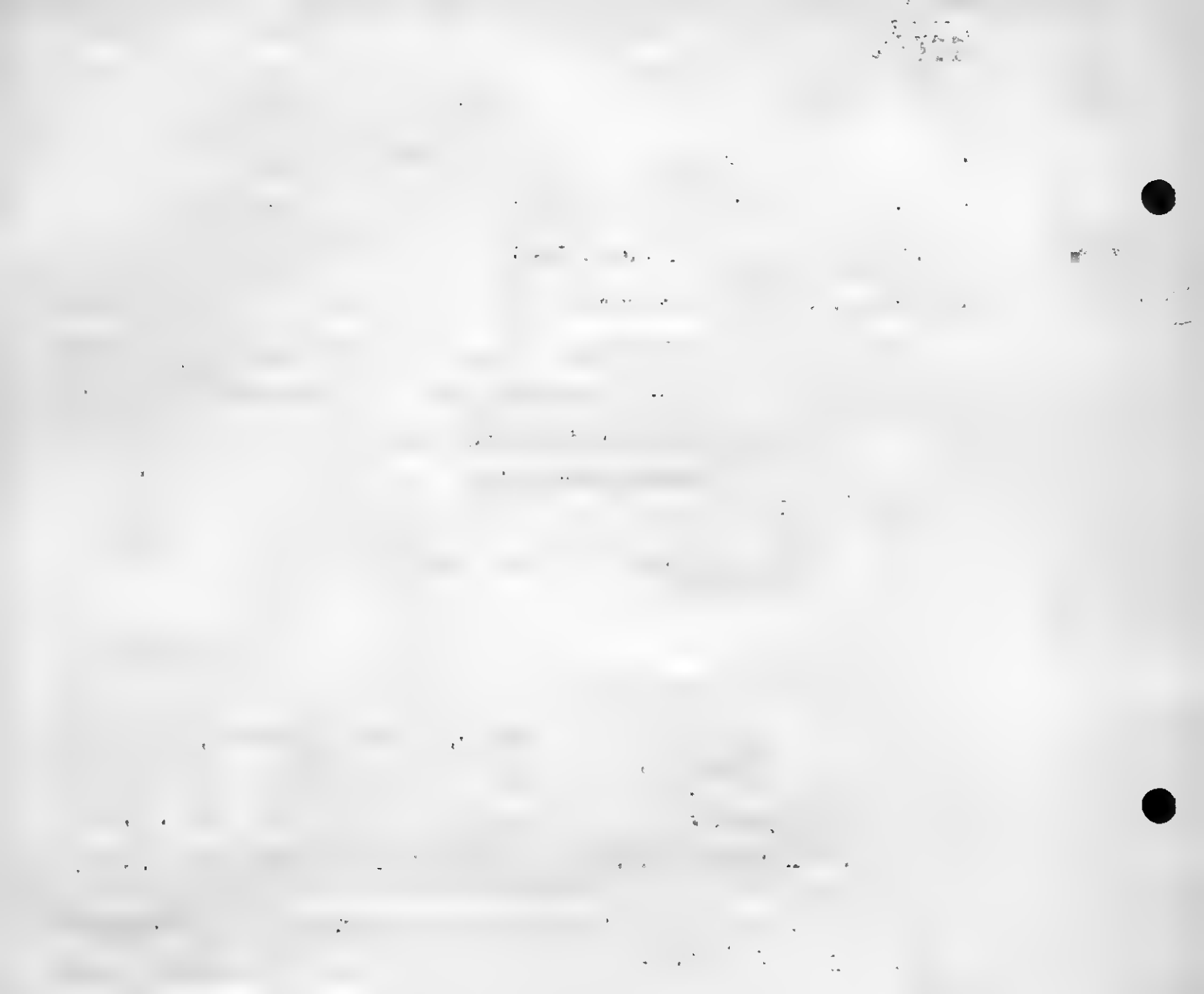
11441

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
Raymond				Fisher	August 29 1968		4 p. M.		
3 SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER YEAR MONTHS DAYS HOURS M.N.		
Male	Negro		April 4, 1886		82 YRS.				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland	U. S. A.				Dorchester, Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Cambridge		Cambridge-Md. Hospital		Day Laborer		Farm			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland R. F. D. 2		Dorchester		Vienna					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Peter A Fisher			Elizabeth A. Carr						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT					
No		214-36-5169		Mrs. Lettie M. Young-East New Market, Md. R. F. D.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia due to urinary retention 600X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 610X Prostatic hypertrophy DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic cardiovascular renal disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Nov 10, 1967, to August 29, 1968, that (I) (we) last saw the deceased alive on August 29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (Type)		J. EDWIN FASSETT, M.D.		22e. ADDRESS 823 HIGH STREET, CAMBRIDGE, MD. 21613					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		9/1/68		Aireys Cemetery		Vienna		Dorchester Md.	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
J. J. Frampton & Son, Federalburg, Maryland				SEP 9 1968		Charles Judge			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

11442										MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										11450									
1. DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
Dora Jeanette Gallagher										Month Aug Day 24 Year 1968										9 P.M.									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS														
Female			White			Nov. 23, 1879			88 YRS.			MONTHS			DAYS			HOURS			MIN								
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Maryland			U.S.A.						Dorchester																				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY																				
Rhodesdale			Rural			Housework			Home																				
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER																	
Md.			Dorchester			Rhodesdale			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rural																	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																										
Eugene -- Coulbourn			Linda -- Thomas																										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address																				
No			217-36-1031			Mrs. Charles Hurlock, Rhodesdale, Md.																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cosmancy thrombosis</u>										12 hr.																			
4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u>										5 yr.																			
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last										DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Atherosclerosis</u>										20 yr.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
4211																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
						YES <input type="checkbox"/> NO <input type="checkbox"/>																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
			HOUR A.M. Month Day Year P.M. 19																										
21a. INJURY OCCURRED			21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21c. LOCATION			Street or R.F.D. No.			City or Town			County			State											
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>																													
22a. I certify that (I) (this hospital) attended the deceased from <u>November 6, 1961</u> , to <u>June 19, 1968</u> , that (I) (we) last saw the deceased alive on <u>June 19, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED																				
<u>H. R. Trapnell</u>									8-27-68																				
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS																										
H. R. Trapnell, M.D.			Federalsburg, Md.																										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)			(County)			(State)														
Burial			Aug 28, 1968			Hill Crest Cem.			Federalsburg, Car.			Md.																	
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE																							
J. J. Thompson & Son, Federalsburg, Maryland			DATE AUG 30 1968			J. Charles Judge																							

1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
11443 CERTIFICATE OF DEATH 1151									
1. DECEASED NAME (Type or print) <b>ERNEST L. GILBERT, Sr.</b>			First Middle Last			2a. DATE OF DEATH Month <b>Aug.</b> Day <b>25</b> Year <b>1968</b>			2b. HOUR M.
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>Dec. 21, 1911</b>		6. AGE (In years last birthday) <b>56</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Dorchester</b> Md			
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Cambridge Md. Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Tool &amp; Die Maker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Electronics</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Cambridge</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1102 Glover Street</b>	
14. FATHER'S NAME First Middle Last <b>Nathan C. Gilbert</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Clara ? Todd</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>unk</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT Address <b>LeCompte Funeral Service records</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4104 Coronary occlusion</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>8/22/68</b> 19, to <b>8/25/68</b> 19, that (I) (we) last saw the deceased alive on <b>8/25/68</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Lawrence Maryann MD</b>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>8/26/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Lawrence Maryann</b>		22e. ADDRESS <b>610 Race St Cambridge, Md</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Aug. 28, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Smyrna, Delaware</b>			
24. FUNERAL DIRECTOR ADDRESS <b>LeCompte Funeral Service, Cambridge, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 28 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Jones</b>			

2005

11444

11:52

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>VIOLA</b>			First Middle Last <b>-----</b>			2a. DATE OF DEATH Month Day Year <b>8 20 68</b>			2b. HOUR M <b>68</b>		
3. SEX <b>FEMALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>12-03-87</b>			6. AGE (In years last birthday) <b>80</b> YRS		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>DORCHESTER</b>		
10. CITY OR TOWN OF DEATH <b>CAMBRIDGE</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>EASTERN SHORE STATE HOSP.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>WICOMICO</b>			13c. CITY OR TOWN <b>SALISBURY</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>192 OCEAN CITY ROAD</b>			14. FATHER'S NAME First Middle Last <b>SIDNEY JONES</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>JENNIE HAMMOND</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) (If yes give war or dates of service) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>214-28-7971</b>			17. INFORMANT (Husband) Mr. Herman Givans, 192 Ocean City Rd. <b>RECORDS OF THE EASTERN SHORE STATE HOSPITAL</b>			Address <b>Salisbury, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute massive pul. emboli</b> 6 hrs. <b>129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>4500</b> (b) <b>Femoral thrombophlebitis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized atherosclerosis</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION, GIVEN IN PART 1 (c) <b>Atherosclerotic heart disease, emaciation.</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/23</b> , 19 <b>68</b> , to <b>8/20</b> /19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/20/68</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>FARUK OZER</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>8/20/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>FARUK OZER</b>						22e. ADDRESS <b>EASTERN SHORE STATE HOSPITAL</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>August 23, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Wicomico, Maryland</b>		
24. FUNERAL DIRECTOR ADDRESS <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>						25a. REC'D BY REGISTRAR DATE <b>AUG 26 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



11445

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 14 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11:53

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) <b>Hubert Cooper Harper</b>			2a. DATE KNOWN OF DEATH Month <b>8</b> Day <b>1</b> Year <b>1968</b>			2b. HOUR OF DEATH M <b>8</b> P <b>M</b>		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>01-30-92</b>	6. AGE (In years last birthday) <b>76 YRS</b>	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>8</b> Day <b>1</b> Year <b>1968</b>		
7a. BIRTHPLACE (State or foreign country) <b>md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Dorchester</b>		
10. CITY OR TOWN OF DEATH <b>Rural-Cambridge</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Eastern Shore State Hosp</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>md.</b>			13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Norfolk</b>		13e. STREET AND NUMBER	
14. FATHER'S NAME First <b>John</b> Middle <b>Darrell</b> Last <b>A. Harper</b>			15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Wright</b> Last <b>Harper</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>34-30-1588</b>			17. INFORMANT <b>Med. Records</b> ADDRESS <b>Eastern Shore State Hospital</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>77X</b> (b) <b>Terminal Neck Tumor</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>4 weeks</b>								
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <b>9 AM 7/4/68</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Fell in hospital</b>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Hospital</b>			21f. LOCATION Street or R.F.D. No. <b>R.F.D. Cambridge Co. Md.</b>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>John Mace Jr.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>8/2/68</b>		
EXAMINER'S NAME (Type) <b>JOHN MACE JR.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <b>8/5/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Washington</b>		
23d. LOCATION (City or Town) (County) (State) <b>Norfolk Dor Md</b>			24. FUNERAL DIRECTOR <b>Edith S. Hollingsby, East New Market</b>			25a. REC'D BY REGISTRAR <b>DATE AUG 8 1968</b>		
25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>								





FOR STATE  
HEALTH DEPT.

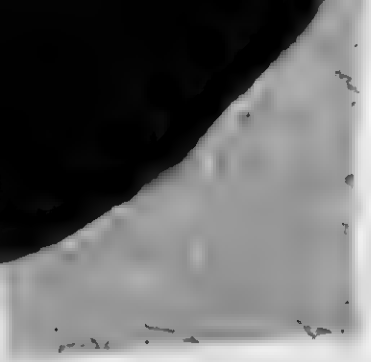
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PNG. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, at any event within 72 hours after death.

11440

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY in 1b <u>Several yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Hotel</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; a. STATE <u>Md</u> b. COUNTY <u>Do</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> d. STREET ADDRESS <u>High St.</u> e. IS RESID ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Wesley</u> Last <u>Hastings</u>				4. DATE OF DEATH Month <u>8</u> Day <u>5</u> Year <u>1968</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>4/28/1908</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Charles Hastings</u>			
14. MOTHER'S MAIDEN NAME <u>Daisy Mowbray</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>110</u>				17. INFORMANT <u>Elmer Hastings, Hurlock, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4104 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
22. DATE SIGNED <u>8/6/68</u>				23. ADDRESS (Street, city, town, or county) <u>Cambridge, Md.</u>			
24. ACTUAL SIGNATURE <u>John Mace Jr.</u> EXAMINER'S NAME (Type) <u>John Mace Jr. M.D.</u>				25. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
26. BURIAL, CREMATION, REMOVAL (Specify)		27. DATE THEREOF		28. NAME OF CEMETERY OR CREMATORY		29. LOCATION (City, town or county) (State)	
<u>Burial</u>		<u>8/6/68</u>		<u>Washington</u>		<u>Hurlock Dor Md</u>	
30. FUNERAL DIRECTOR <u>Keith S. Hullozky</u> ADDRESS <u>East New Market, Md</u>				31. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>AUG 8 1968</u>			



11/11/11



11447

## CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>ALONZA G. HILL</b>			2a. DATE OF DEATH Month <b>Aug.</b> Day <b>11</b> Year <b>1968</b>			2b. HOUR <b>12:30</b> A M	
3 SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Oct. 10, 1890</b>		6. AGE (In years lost birthday) <b>77</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Dorchester</b>	
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Cambridge Md. Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer-Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>retired</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Cambridge</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME First <b>John</b> Middle <b>?</b> Last <b>Hill</b>		15. MOTHER'S MAIDEN NAME First <b>Amanda</b> Middle <b>?</b> Last <b>Warfield</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>- - -</b>			
16b. SOCIAL SECURITY NO <b>- - -</b>		17. INFORMANT Address <b>LeCompte Funeral Service records</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BLOOD LOSS SHOCK</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>BLEEDING CARCINOMA OF DUODENUM</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>- - -</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 HOUR</b> <b>1-2 HOUR</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8-10, 1968</b> , to <b>8-11, 1968</b> , that <input checked="" type="checkbox"/> (we) lost the deceased alive on <b>8-11, 1968</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (I) (we) <input checked="" type="checkbox"/> (did) (did not) view the body after death.							
22b. SIGNATURE <b>James F. McCarter</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>8-13-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>James F. McCarter, M.D.</b>				22e. ADDRESS <b>704 Locust Street Cambridge, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Aug 13, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spadden-Seward Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cambridge, RFD3, Maryland</b>	
24. FUNERAL DIRECTOR ADDRESS <b>LeCompte Funeral Service, Cambridge, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

11448

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11456

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH			<input checked="" type="checkbox"/> Month	Day	Year	2b. HOUR
Ida				Meta	Hoge	August 1968					1968	87A M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. UNDER 1 YEAR	8. UNDER 24 HRS	2c. DATE PRONOUNCED DEAD			Month	Day	Year	2d. HOUR
Female	White	June 15, 1886	82 YRS								19	M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Germany		U.S.				Dorchester			Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Cambridge			Cambridge- Md. Hospital			Housewife						
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER
Id.			Dorchester			Cambridge			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			411 E. Appleby Ave.
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
Frank					Fleischman	Matilda					Keene	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes-no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS			
No						Earl Hoge			Somerset Ave. Cambridge Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion											30 Mins.	
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?		
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
			HOUR A.M. P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
			John Hoge Jr. M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			8/6/68			
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			
									Cambridge, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			8/6/68		Dorchester Mem. Park			Cambridge Dorchester Md.				
24. FUNERAL DIRECTOR						ADDRESS		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
						Cambridge Md.		DATE AUG 9 1968				

3.184.27



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**FOR STATE  
HEALTH DEPT.**

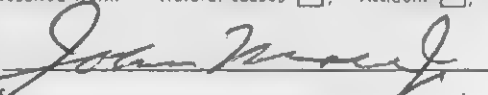

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11442

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1 DECEASED-NAME (Type or Print) <b>MITCHELL W. HORWATH</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> EST. <input type="checkbox"/> MATED <input type="checkbox"/> <b>Aug 30 1968</b>			2b. HOUR <b>8:25 PM</b>		
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>July 4, 1893</b>	6 AGE (in years last birthday) <b>75 YRS</b>	7 UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month <b>8</b> Day <b>30</b> Year <b>1968</b>		
7a. BIRTHPLACE (State or foreign country) <b>Kansas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>Dorchester</b>		
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>DOA Cambridge Md. Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of work life even if retired) <b>Farmer-Waterman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Cambridge</b>		13d. INS OF CITY & HTS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>617 Race Street</b>
14. FATHER'S NAME First <b>Michael</b> Middle <b>?</b> Last <b>Horwath</b>			15. MOTHER'S MAIDEN NAME First <b>Marie</b> Middle <b>?</b> Last <b>Stettner</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>217-10-8887</b>		17. INFORMANT <b>LeCompte Funeral Service records</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Subdural hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Fracture of skull</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>few mins.</b>							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <b>8:30 P.M. 8/30/68</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) <b>Fell in alley.</b>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Alley</b>		21f. LOCATION Street or R.F.D. No <b>Dunns Alley</b> City or Town <b>Cambridge, Md.</b> County <b>Dor.</b> State <b>Co.</b>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE 			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>9/2/68</b>		
EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town or county) <b>Cambridge, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Sept. 2, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cambridge, Maryland</b>		
24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>				25a. REC'D BY REG STRAR DATE <b>SEP 5 1968</b>		25b. REGISTRAR'S SIGNATURE 		



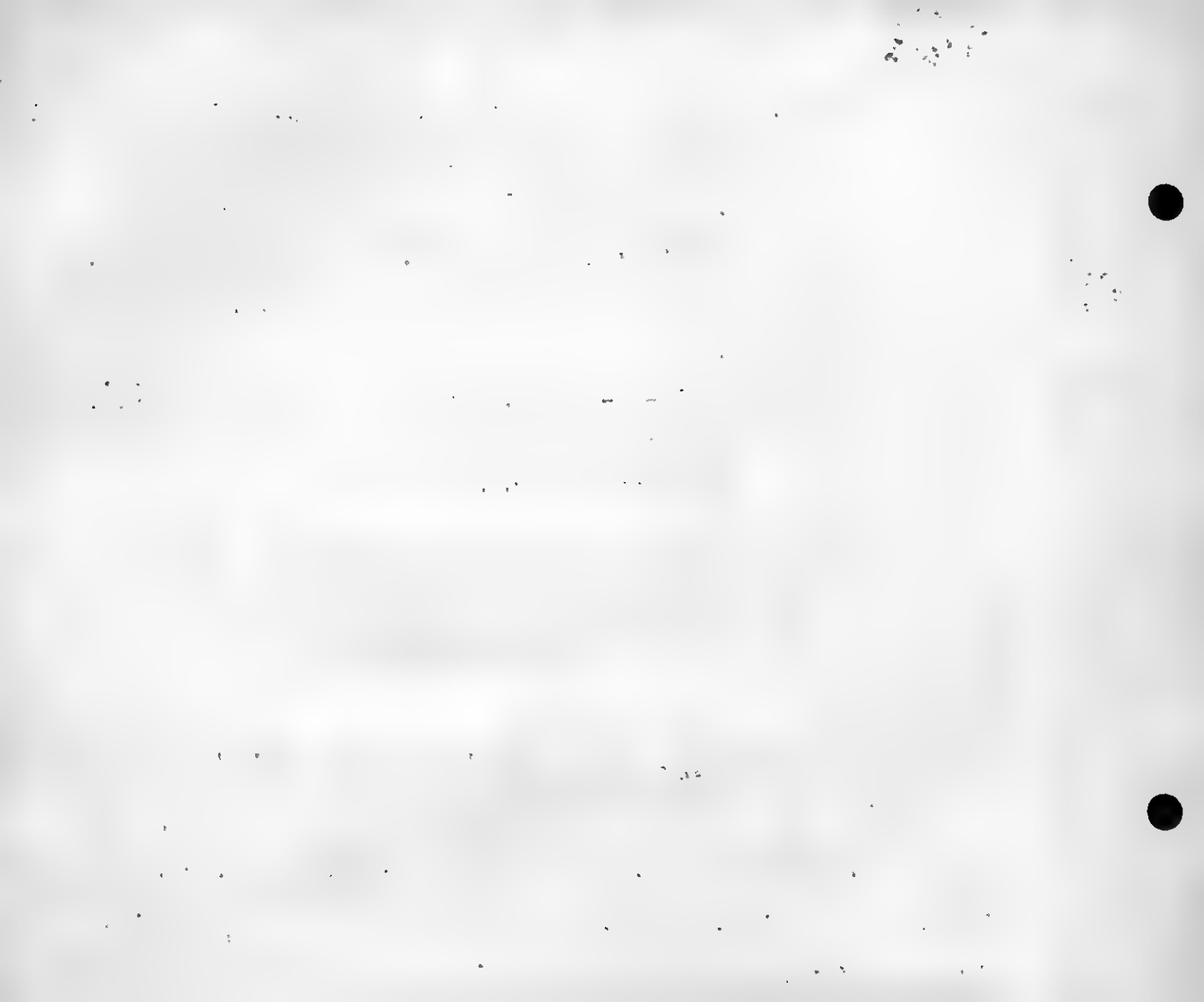


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

VR A15 (3)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) <b>William Carl Humphreys</b>						2a. DATE OF DEATH Month <b>Aug.</b> Day <b>7</b> Year <b>1968</b>			2b. HOUR <b>8 P M</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 2, 1892</b>		6. AGE (in years last birthday) <b>75</b> YRS		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS M.N.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Dorchester</b> Md.					
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Cambridge-Maryland Hosp.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Carpenter</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Cambridge</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>R.F.D. 1</b>			
14. FATHER'S NAME First Middle Last <b>William J. Humphreys</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Amanda Thompson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <b>216-18-2110</b>		17. INFORMANT <b>Cambridge, Md. Mrs. Marian M. Humphreys, D.D. 1</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4129 Cardiovascular accident</b> DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic H.D.</b> (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>42</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>May 6, 1968</b> , to <b>Aug. 7, 1968</b> , that (I) (we) last saw the deceased alive on <b>August 8, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <b>[Signature]</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Aug. 9, '68</b>			
22d. PHYSICIAN'S NAME (Type) <b>EDWIN FASSETT, M.D.</b>						22e. ADDRESS <b>623 HIGH STREET, CAMB., Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Aug. 17, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park, Cambridge, Md.</b>		23d. LOCATION (City or Town) (County) (State) <b>Dor</b>					
24. FUNERAL DIRECTOR <b>Kenneth D. Thomas</b>						ADDRESS <b>Cambridge, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 14 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



FOR STATE  
HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)		First John		Middle Emory		Last Hurlock, Jr.,		2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year 8/27 1968		2b HOUR P M 6 P M	
3 SEX Male	4 RACE White	5 DATE OF BIRTH Aug. 17, 1906		6 AGE (In years last birthday) YRS MONTHS DAYS 62 0 0		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year 8 27 19		2d HOUR P M P M	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Dorchester					
1d CITY OR TOWN OF DEATH Cambridge, Md.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Route to Cambridge		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) House Painter		12b KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b COUNTY Dorchester		13c CITY OR TOWN Cambridge		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER Rural			
14 FATHER'S NAME First Middle Last John Emory Hurlock				15 MOTHER'S MAIDEN NAME First Middle Last Anna Shenton							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO. (If yes give war or dates of service)		17 INFORMANT Mrs. Alice T. Hurlock, Cambridge, Md.				ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 Mins.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) 42c											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				2d AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No				City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John W. Ace Jr., M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 8/28/68			
ADDRESS (Street, city, town, or county)		Cambridge, Md.									
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Aug. 30, 1968		23c. NAME OF CEMETERY OR CREMATORY Pliott Churchyard				23d LOCATION (City or Town) (County) (State) Pliott Dor. Md.			
24 FUNERAL DIRECTOR Kenneth R. Thomas				ADDRESS Cambridge, Md.				25a. REC'D BY REGISTRAR DATE SEP 5 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

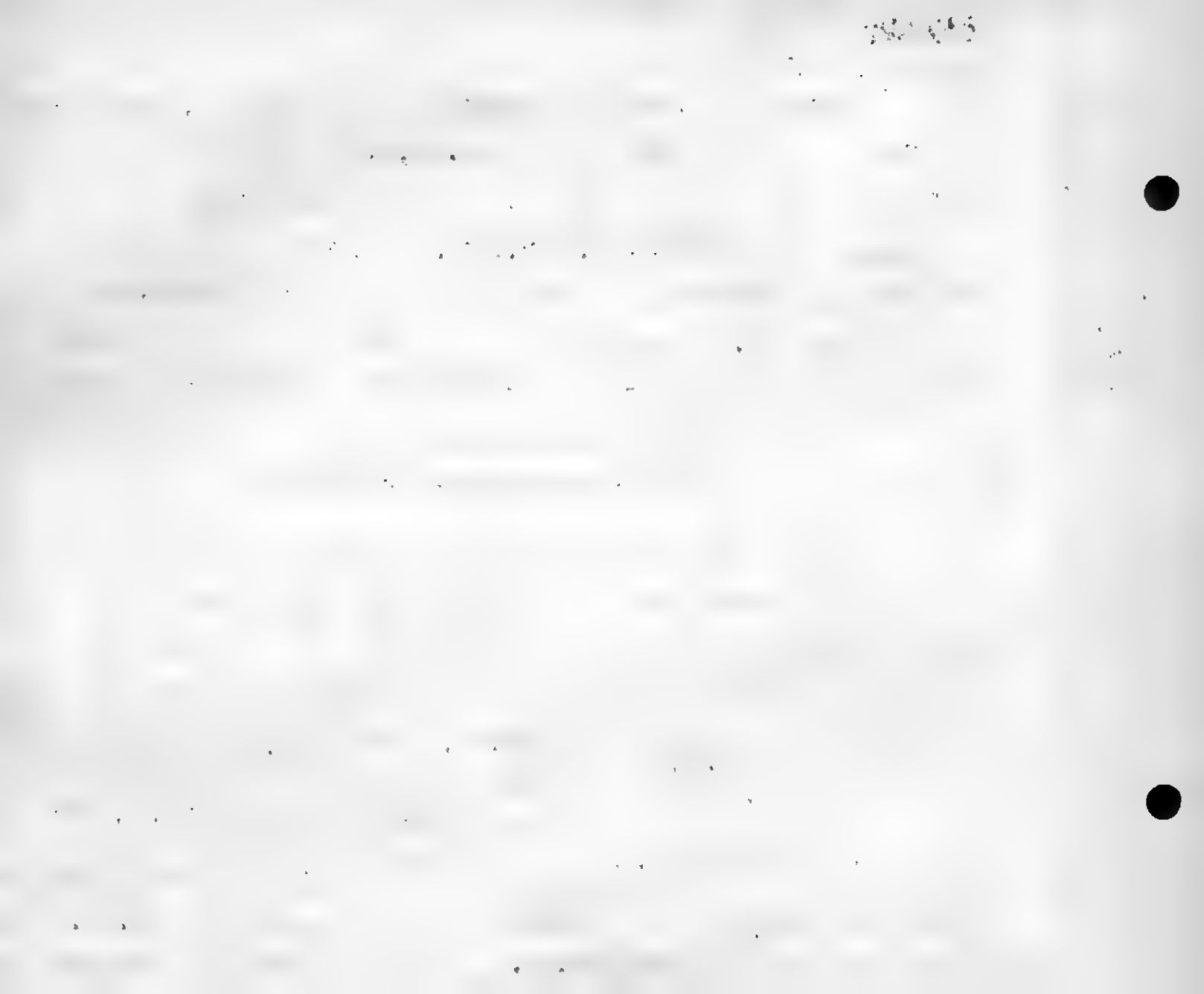
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11452

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1968

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH			2b HOUR	
THOMAS JAMES JOHNSON						AUGUST 4, 1968			3:00p M	
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS
MALE		NEGROID		OCT. 24, 1888		79 YRS.		MONTHS		DAYS
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND		USA				DORCHESTER Md				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
CAMBRIDGE			CAMBRIDGE MD. HOSP., INC.			LABORER				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d INS-OR CITY LIMITS?		13e. STREET AND NUMBER	
MARYLAND			DORCHESTER		CAMBRIDGE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		602 EDGEWOOD AVENUE	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
GEORGE W. JOHNSON			ELLA JAMES							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b SOCIAL SECURITY NO.		17. INFORMANT Address					
NO			212-12-5662		VATICE COLDER 516 PINE STREET 21613					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident										
DUE TO, OR AS A CONSEQUENCE OF arteriosclerotic cardiovascular disease										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No		City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from April 2, 1967, to Aug. 4, 1968, that (I) (we) lost the deceased on Aug. 4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (aid) (and) (not) view the body after death.										
22b SIGNATURE					DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED
										Aug. 5, 1968
22d. PHYSICIAN'S NAME (Type) J. EDWIN FASSETT, M.D.					22e. ADDRESS					
					623 HIGH STREET, CAMBRIDGE, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town)		(County)	(State)	
BURIAL		8/7/68		BETHEL		CAMBRIDGE		DOR.	MD.	
24. FUNERAL DIRECTOR					ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
The Rev. C. St. Onis					CAMBRIDGE, MD.			DATE AUG 8 1968		Charles Judge



FOR STATE  
HEALTH DEPT.11457 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 2, Film 3404 9/MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1961

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		Month		Day		Year		2b HOUR							
Wilson		Levin		Jones				M		18		30		1968		M							
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		F UNDER 24 HRS		2c DATE PRONOUNCED DEAD		Month		Day		2d HOUR							
Male	White	Feb. 21, 1903		45 YRS		MONTHS		DAYS		HOURS		MIN		Aug.		2, 1968 P.M.							
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9. COUNTY OF DEATH								Md.							
Maryland		U.S.		WIDOWED		DIVORCED		Dorchester															
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY																	
Lincolnton		Rural		Laborer																			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY - HOUSE?		13e STREET AND NUMBER															
Maryland		Dorchester		Lincolnton		YES <input type="checkbox"/> NO <input type="checkbox"/>		Rural															
14 FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last									
Edward		James		Jones				Mary		Maline		Elizabeth											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS															
						Herbert P. Jones, Cambridge, Md., U.D. 2																	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion															Instant								
4109 DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																							
(b) DUE TO, OR AS A CONSEQUENCE OF																							
(c)																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
420																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY?											
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)															
				HOUR A M P.M. 19																			
21a INJURY OCCURRED				21b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No				City or Town				County				State			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>																							
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b DATE SIGNED							
EXAMINER'S NAME (Type)				John Mace Jr.				ADDRESS (Street, city, town, or county)								8/31/68							
23a BURIAL CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town)				(County)				(State)			
Buried				Sept. 2, 1968				Jones Family Cemetery, Lincolnton				Lincolnton				Md.							
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE											
Kenneth A. Thomas				Cambridge, Md.				DATE SEP 5 1968				Charles Judge											

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1, 2, and 3, and to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-2. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 (Post-mortem). 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**11454 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		Month		Day		Year		24 HOUR			
GOLDA		WILLEY		LAWSON				MATED		Aug. 31		1968				P. M.			
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years past birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		Month		Day		24 HOUR			
Female	White	Oct. 31, 1897		70 YRS		MONTHS DAYS		HOURS MIN		8		31		1968		P. M.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH								Md			
Maryland		USA		WIDOWED		DIVORCED		Dorchester											
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY													
Cambridge		Cambridge Md. Hospital		Housewife		Home													
13a USUAL RESIDENCE (Where deceased lived, if not in hospital residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER											
Maryland		Dorchester		Cambridge		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RFD No. 2, Drawbridge											
14. FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last					
Daniel J. Willey								Alberta											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		unk		LeCompte Funeral Service records															
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:																Instant			
IMMEDIATE CAUSE (a) Coronary occlusion																			
4109 DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																			
(b) DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
7201 Fracture neck right femur																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?											
12/5/68				Fracture neck r. femur				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
				10 AM 11/30/1967				Slipped and fell on ice.											
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or RFD No.				City or Town							
				Home				R.F.D. 2				Cambridge Dor. Md.							
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED							
EXAMINER'S NAME (Type)				John Mace Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				9/2/68							
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)							
23a BURIAL-CREMAATION REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)							
Burial				Sept 3 1968				Dorchester Memorial Park				Cambridge, Maryland							
24 FUNERAL DIRECTOR								ADDRESS				25a REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE			
LeCompte Funeral Service, Cambridge, Maryland												DATE SEP 5 1968				J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/78

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
11453		Arthur		Maddox	Month	Day	Year	3 P M	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		7 UNDER 1 YEAR		8 UNDER 24 HRS.
Male	Negro		01-19-88		86 YRS.		MONTHS		DAYS
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.		U.S.A.				Dorchester Md.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Rural-Cambridge		Eastern Shore State Hosp		Farmer					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.		Somerset		Fairmont		YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Robert		Margaret Maddox							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17 INFORMANT					
No		Unknown		Med. Records Eastern Shore State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT								1 day	
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS GENERAL AND CEREBRAL									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21c. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4-18-1968, to 8-2-1968, that (I) (we) lost saw the deceased alive on 8-2-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				22c. DATE SIGNED					
Miguel A. de la Guardia, M.D.				8/2/68					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Miguel A. de la Guardia, M.D.				E.S.S.H.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		8/6/68		Centennial		Fairmont, Maryland			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
William H. Davis				AUG 8 1968		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

VR 1-3  
304 REV. 1-68

11455										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										11-64									
1										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print)					First		Middle		Last		2a. DATE OF DEATH					2b. HOUR													
CHARLES					WESLEY		OPHER		AUGUST 7, 1968					2:25p M															
3 SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR		IF UNDER 24 HRS.															
MALE			NEGRO ID			JANUARY 1, 1904			64 YRS.			MONTHS DAYS		HOURS MIN															
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9 COUNTY OF DEATH														
MARYLAND					USA										DORCHESTER Md														
10 CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b. KIND OF BUSINESS OR INDUSTRY														
CAMBRIDGE					CAMBRIDGE MD. HOSP., INC.					LABORER																			
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before address) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER									
MARYLAND					DORCHESTER					CAMBRIDGE					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					921 PINE STREET									
14 FATHER'S NAME					First		Middle		Last		15 MOTHER'S MAIDEN NAME					First		Middle		Last									
ANDREW									OPHER		SOPHIA									CAMPER									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown					(If yes give year or dates of service)					16b. SOCIAL SECURITY NO					17. INFORMANT					Address									
NO										214-07-8949					ELLA OPPER					921 HIGH ST. CAMB., MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										Uremia																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										DUE TO, OR AS A CONSEQUENCE OF																			
										Cardiac Decompensation																			
										DUE TO, OR AS A CONSEQUENCE OF																			
										Hypertension Arteriosclerotic CVRD																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC										21f. LOCATION Street or R.F.D. No City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from Dec. 26, 1968 to Aug. 7, 1968, that (I) (we) lost saw the deceased alive on August 7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and) (not) view the body after death.																													
22b. SIGNATURE										DEGREE										ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					22c. DATE SIGNED Aug. 9, '68				
22d. PHYSICIAN'S NAME (Type)										EDWIN FASSETT, M.D.										22e. ADDRESS 603 HIGH STREET, CAMBRIDGE, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
BURIAL					8/11/68					BETHEL					CAMBRIDGE DOR. MD														
24. FUNERAL DIRECTOR					ST. CLAIR FUNERAL H. CAMBRIDGE, MD.					25a. REC'D BY REGISTRAR AUG 16 1968					25b. REGISTRAR'S SIGNATURE														



10/1/73



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print)			First Fked			Middle E.			Last Prettyman		
3 SEX Male			4 RACE White		5 DATE OF BIRTH 6/17/1899		6 AGE (in years last birthday) 69 YRS		7c DATE PRONOUNCED DEAD Month 8 Day 7 Year 1968		
7a BIRTHPLACE (State or foreign country) Delaware			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Dorchester		
10 CITY OR TOWN OF DEATH Cambridge			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hosp.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer			12b KIND OF BUSINESS OR INDUSTRY Farm.		
13a USUAL RESIDENCE (Where deceased admission) STATE Md.			13b COUNTY Dor.			13c CITY OR TOWN Cambridge			13d STREET AND NUMBER 203 Hayward St.		
14 FATHER'S NAME First Edward			Middle Prettyman			Last Lou			15 MOTHER'S MAIDEN NAME First Roach		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) No			16b SOCIAL SECURITY NO (If yes give war or dates of service) 217-54-5520			17 INFORMANT Mrs. Pearl McDowell, Cambridge, Md.			ADDRESS		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4109 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 Mins.										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201	
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Mace Jr. M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED 8/10/68			ADDRESS (Street, city, town, or county) Cambridge, Md.		
23a BURIAL CREMATION, REMOVAL (Specify) Burial			23b DATE 8/10/68			23c NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery			23d LOCATION (City or Town) (County) (State) Laurel Del.		
24 FUNERAL DIRECTOR Windsor & Disharoon			ADDRESS Laurel, Del.			25a REC'D BY REGISTRAR DATE AUG 14 1968			25b REGISTRAR'S SIGNATURE Charles Judge		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 3/68

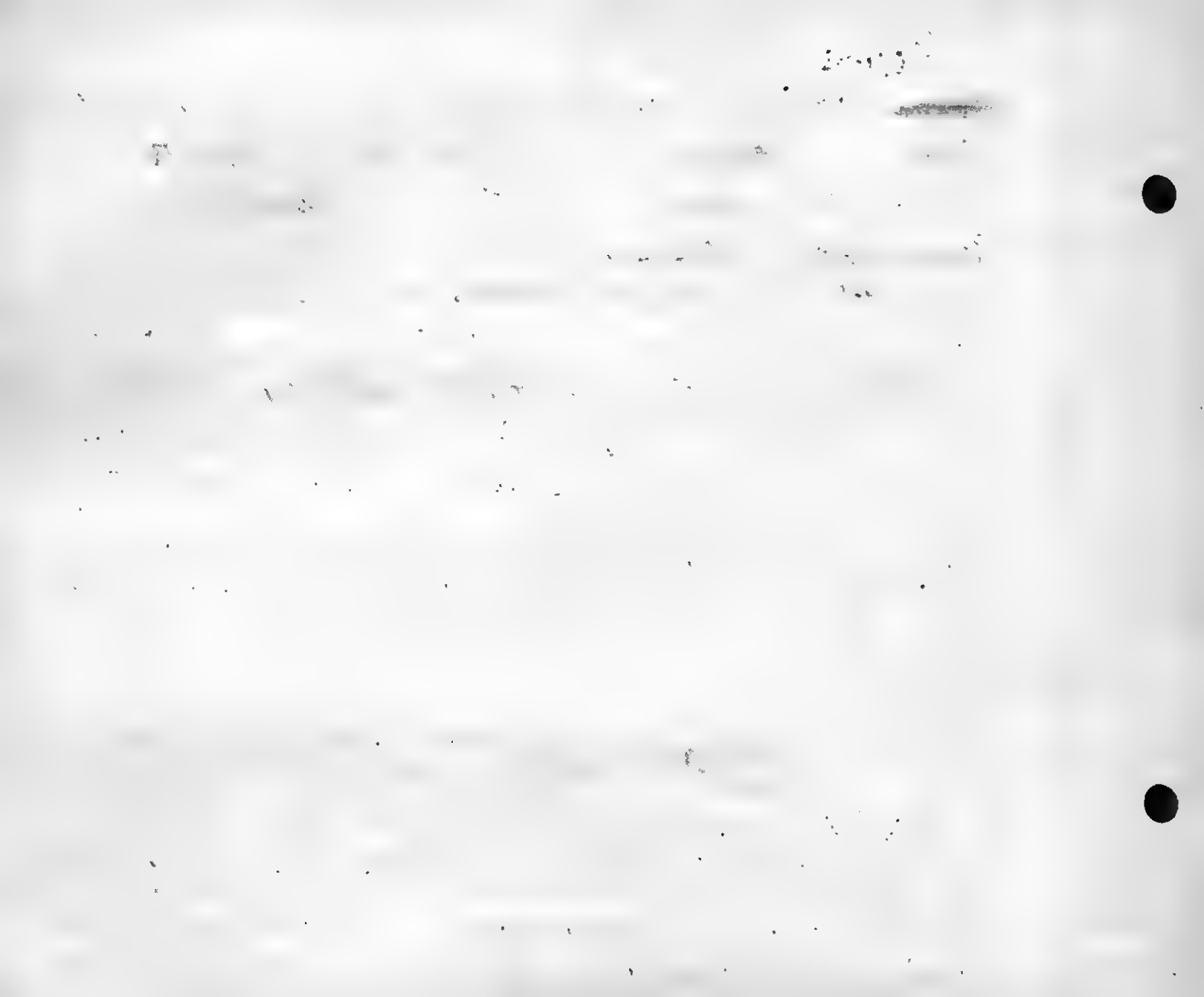
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11166

11455

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <b>ISAAC A QUEEN</b>			2a. DATE OF DEATH Month <b>8</b> Day <b>4</b> Year <b>1968</b>			2b. HOUR <b>8 30 A M</b>	
3. SEX <b>Male</b>		4 RACE <b>Negro</b>		5. DATE OF BIRTH <b>8-12-85</b>		6 AGE (n years last birthday) <b>82 YRS</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Dorchester</b> Md	
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>E.S.S.H.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>waiter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>TALBOT</b>		13c. CITY OR TOWN <b>Oxford</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>Box 355</b>		14. FATHER'S NAME First <b>John</b> Middle <b>Queen</b> Last <b>Queen</b>		15. MOTHER'S MAIDEN NAME First <b>Pricilla</b> Middle <b>Unknown</b> Last <b>Unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>212 07 371</b>		17. INFORMANT <b>Hytalia Bailey</b>		Address <b>Oxford, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Apnea</b> <b>125x</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic Adenocarcinoma of Prostate</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>17 yrs.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 mcs.</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>the inj.</b> <b>Pleural Effusion, Coronary Artery Disease, gen. Cerebral Arteriosclerosis.</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>5-18</b> , 19 <b>67</b> , to <b>8-4</b> , 19 <b>68</b> , that (I) (we) lost the deceased alive on <b>8-3-68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>DONALD A. KELLOGG MD</b>				DEGREE <b>MD</b> ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>8/4/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>DONALD A. KELLOGG</b>				22e. ADDRESS <b>EASTERN SHORE STATE HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Aug. 7, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Screamersville</b>		23d. LOCATION (City or Town) (County) (State) <b>Oxford Talbot Maryland</b>	
24. FUNERAL DIRECTOR <b>B E Darwell</b>		ADDRESS <b>426 Ocean Ave</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 7 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>	

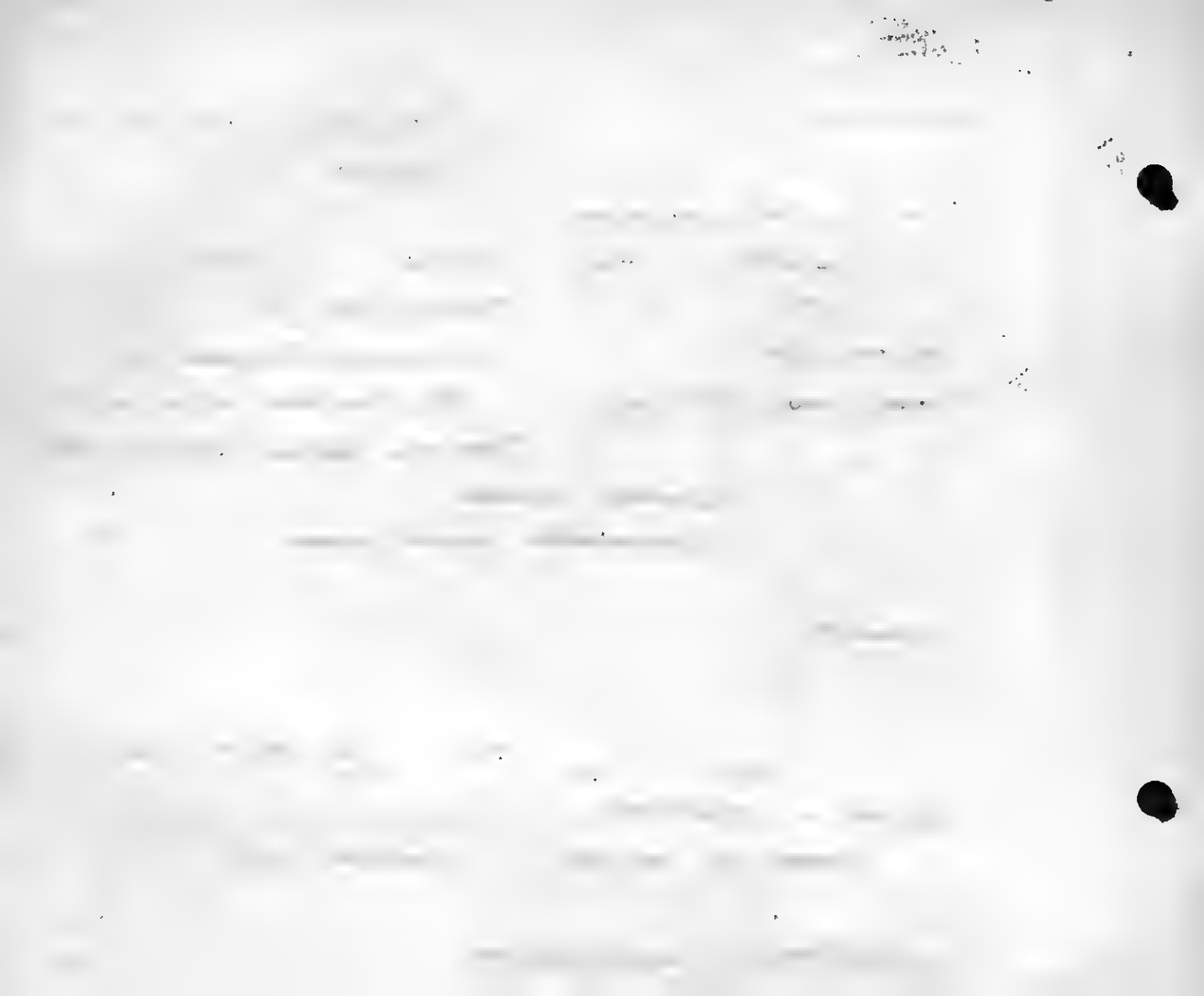


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
11452  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glasgow Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Vienna</b> d. STREET ADDRESS <b>Vienna</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Kemma</b> Middle <b>Ann</b> Last <b>Reid</b>		4. DATE OF DEATH Month <b>8</b> Day <b>15</b> Year <b>1968</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/29/1892</b>
9. AGE (in years last birthday) <b>86 yrs.</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>10</b> Hours <b>10</b> Min. <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTH PLACE (County & State, or foreign country) <b>Dorchester Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>Mingos Louis Henry</b>		14. MOTHER'S MAIDEN NAME <b>Martha Ann Le Compte</b>	
15. WAS DECLARED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Thema Ganga Salisbury Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11-7</b> , 19 <b>67</b> , to <b>8-15</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8-12</b> , 19 <b>68</b> , and that death occurred at <b>2 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Richard G. Bilodeau</b>		22b. DATE SIGNED <b>8-15-68</b>	
22c. PHYSICIAN'S NAME (Type) <b>RICHARD G. BILODEAU</b>		22d. ADDRESS <b>CAMBRIDGE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>Aug. 17, 1968</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park Cambridge, Md.</b>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <b>Herbert Thomas J. Cambridge Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>AUG 26 1968</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
11461  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>PORCHESTER</b> COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>M.D.</b> b. COUNTY <b>QUEEN ANNES</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE MD</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WYE Mills</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glasgow Nursing Home</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>SARAH (first) Amelia (middle) ROE (last)</b>		4. DATE OF DEATH <b>8 5 1968</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/31/74</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>REGISTERED NURSE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>	9. AGE (In years last birthday) <b>94</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>QUEEN ANNES Co Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDMUND THEODORE ROE</b>		14. MOTHER'S MAIDEN NAME <b>MARY TEMPERANCE COVINGTON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-48-6066</b>	
17. INFORMANT <b>Mrs. Ruth P. Roe, Wye Mills, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 4109 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b> ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>4201</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11-17</b> , 19 <b>67</b> , to <b>8-5</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8-5</b> , 19 <b>68</b> , and that death occurred at <b>5:20 P.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Richard N. Bilodeau</b> M.D.		22b. DATE SIGNED <b>8-5-68</b>	
22c. PHYSICIAN'S NAME (Type) <b>RICHARD G. BILODEAU</b>		22d. ADDRESS <b>CAMBRIDGE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>August 8, 1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Chesterfield Cemetery, Centerville, Queen Anne's Md.</b>	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR <b>James H. Barton, Barton Bros, Centerville, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 9 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11462

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Allie</b> <b>air</b> <b>Smith</b>			2a. DATE OF DEATH Month <b>Aug</b> Day <b>26</b> Year <b>1968</b>		2b. HOUR <b>11P</b> M
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>October 22, 1880</b>		6. AGE (In years last birthday) <b>78</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (State or foreign country) <b> Md. </b>	7b. CITIZEN OF WHAT COUNTRY? <b> U.S. </b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b> Dorchester </b> Md.		
10. CITY OR TOWN OF DEATH <b> Cambridge </b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b> Cambridge - Id. Hospital </b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b> member </b>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b> Md. </b>	13b. CITY OR TOWN <b> Dorchester </b>	13c. INSIDE CITY LIMITS? <b> YES </b> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b> 13 Race St. </b>		
14. FATHER'S NAME <b> George E. Willey </b>	15. MOTHER'S MAIDEN NAME <b> Dorothy Shorter </b>	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO.		17. INFORMANT <b> Mr. Charlie P. Smith Cambridge, Md. </b>			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))					
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b> FAR ADVANCED PULMONARY TUBERCULOSIS </b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <b> YES </b> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year <b> P.M. 19 </b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION	Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <b> Dec. </b> , 19 <b> 67 </b> , to <b> 8-26-68 </b> , 19 <b> </b> , that (I) (we) last saw the deceased alive on <b> 8-26-68 </b> , 19 <b> </b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b> Albert E. Bunker, M.D. </b>		22c. DATE SIGNED <b> 8-28-68 </b>		22d. PHYSICIAN'S NAME (Type) <b> Albert E. Bunker, M. D. </b>	
22e. ADDRESS <b> 200 Md. Ave., Cambridge, Md. 21613 </b>		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b> Aug. 29, 1968 </b>	23c. NAME OF CEMETERY OR CREMATORY <b> Green Lawn Cemetery </b>	23d. LOCATION (City or Town)	(County)	(State) <b> Cambridge Dorchester Md. </b>
24. FUNERAL DIRECTOR <b> Kenneth R. Thompson </b>		ADDRESS <b> Cambridge Md. 21613 </b>		25a. REC'D BY REGISTRAR <b> SEP 5 1968 </b>	25b. REGISTRAR'S SIGNATURE <b> Charles Judge </b>

MEDICAL CERTIFICATION



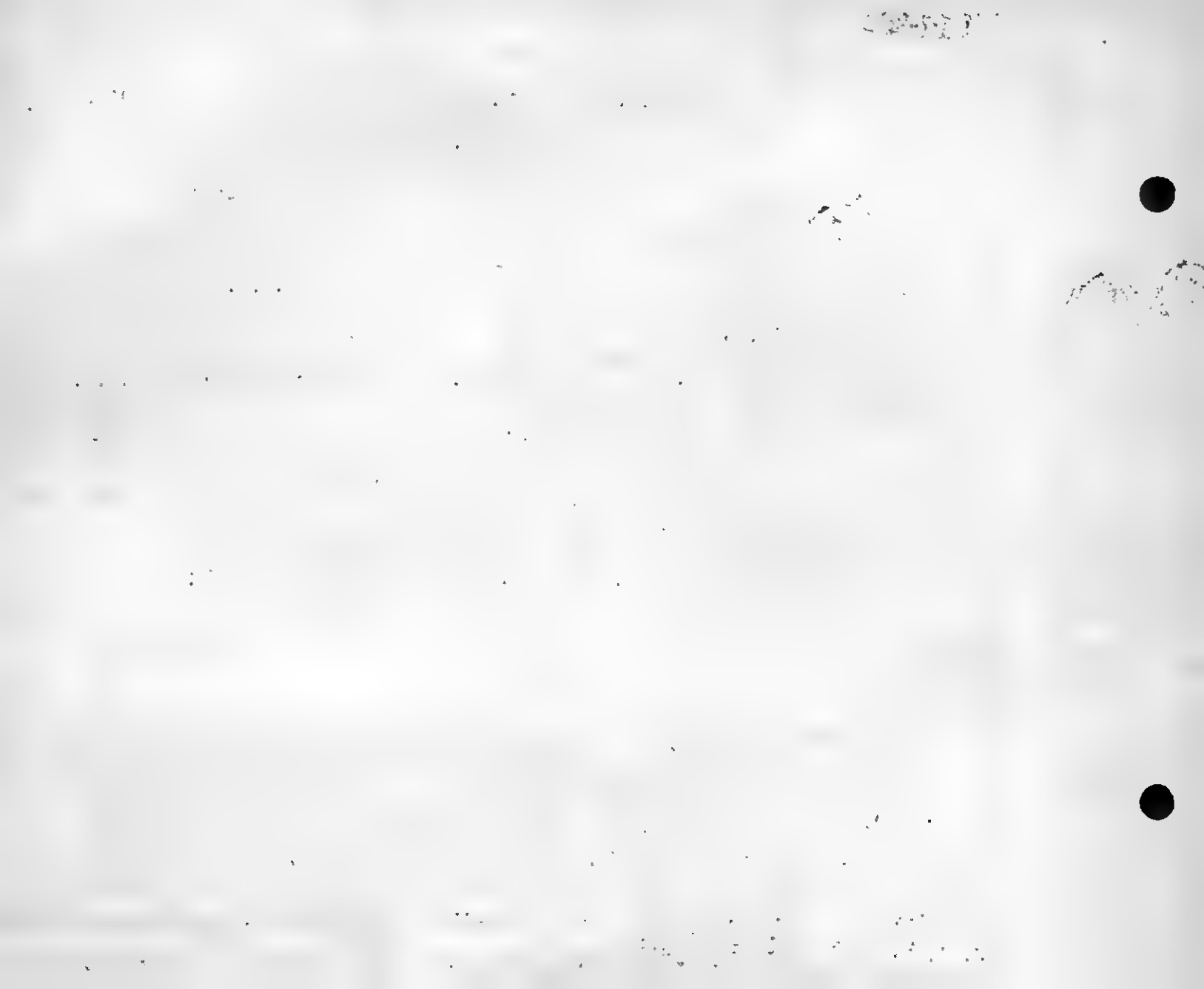


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV 7-59

11462										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										11471									
1 DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First MIDDLE Last										Month Day Year										HOUR MIN									
LENA HARRIETT TODD										August 4 1968										11:10 A.M.									
3 SEX					4 RACE					5. DATE OF BIRTH					6 AGE (In years last birthday)					IF UNDER 1 YEAR					IF UNDER 24 HRS				
Female					White					Jan. 25, 1898					70 YRS.					MONTHS DAYS HOURS MIN									
7a BIRTHPLACE (State or foreign country)					7b CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH														
Maryland					USA										Dorchester Md.														
10 CITY OR TOWN OF DEATH					11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b. KIND OF BUSINESS OR INDUSTRY									
Hurlock					Bellevue Haven Nursing Home										housework					Home									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?					13e. STREET AND NUMBER									
Maryland					Caroline					Preston					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					R.F.D. (Near Harmony)									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																								
First MIDDLE Last					First MIDDLE Last																								
Abijah Ivins					Dora Carroll																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT Address																			
No					None					Alva W. Todd, Preston, Maryland, R.F.D.																			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic congestive cardiac failure															2 yrs														
4101 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Arteriosclerosis															10 yrs														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																													
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis															15 yrs														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
Removal of Carcinoma of Rectum 10yrs old right hemicolectomy																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
					HOUR A.M. Month Day Year P.M. 19																								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)					21f. LOCATION Street or R.F.D. No City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 8/15/68, 19, to 8/17/68, 19, that (I) (we) last saw the deceased alive on 8/17/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE										DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED									
																				8/8/68									
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
Harold B. Fluxus M.D.										Preston Maryland																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					Aug. 7, 1968					Hill Crest Cemetery					Federalsburg, Maryland														
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
J. J. Frampton and Son, Federalsburg, Maryland										DATE AUG 15 1968										Charles Judge									



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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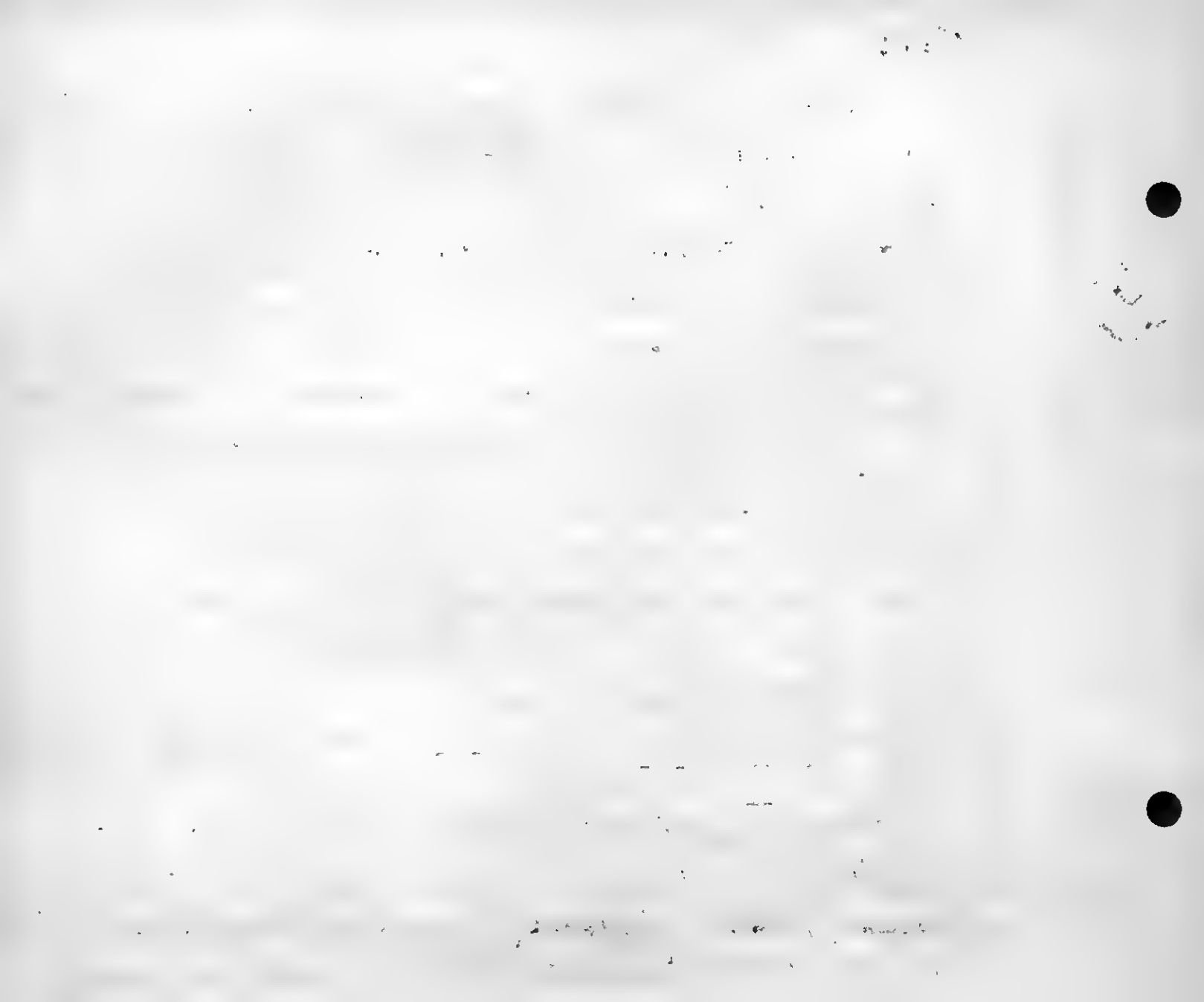
11462

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11570

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>JAMES MCCLELLAND WEBSTER</b>			2a. DATE OF DEATH Month <b>8</b> Day <b>23</b> Year <b>68</b>			2b. HOUR <b>6:25</b> P.M.			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>02-01-86</b>		6. AGE (In years lost birthday) <b>82</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>DORCHESTER</b> Md			
10. CITY OR TOWN OF DEATH <b>CAMBRIDGE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>EASTERN SHORE STATE HOSP.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>MERCHANT</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>SOMERSET</b>		13c. CITY OR TOWN <b>CRISFIELD</b>		13d. INSIDE CITY, LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last <b>ALFRED WEBSTER</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>CHARLOTTE DIZE</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b> (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>RECORDS OF THE EASTERN SHORE STATE HOSPITAL</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>B.P. Branch pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <b>491</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <b>07-12-68</b> , to <b>08-23-68</b> , that (I) (we) lost saw the deceased alive on <b>08-23-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Dr. W. Rieckert</b>					22c. DATE SIGNED <b>8-24-68</b>			22d. PHYSICIAN'S NAME (Type) <b>Dr. W. Rieckert</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>8/26/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gravesbury</b>		23d. LOCATION (City or Town) (County) (State) <b>Crisfield Somerset Md</b>			
24. FUNERAL DIRECTOR <b>James L. Lennan Funeral Home</b>					25a. REC'D BY REGISTRAR <b>DATE AUG 28 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



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11463

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1173

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last SAMUEL PERCY WHEATLEY			2a. DATE OF DEATH Month Day Year August 14 1968		2b. HOUR 4:45 A. M.
3 SEX Male	4 RACE White	5 DATE OF BIRTH October 6, 1909		6. AGE (In years last birthday) 58 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Dorchester		
10 CITY OR TOWN OF DEATH Cambridge	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge-Maryland Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Mechanic and Electric Welder		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Dorchester	13c. CITY OR TOWN Hurlock	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Taylor Avenue	
14. FATHER'S NAME First Middle Last Samuel W. Wheatley			15. MOTHER'S MAIDEN NAME First Middle Last Nettie Medford		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO 220-01-7289		17 INFORMANT Address Mrs. Anna N. Wheatley, Hurlock, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) ARTERIOSELEBROSIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ARTERIOSELEBROSIS					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH TERMINAL 1+ YRS 30 YRS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES MELLITUS					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from AUG 12, 19 68, to AUG. 14, 19 68, that (I) (we) saw the deceased alive on AUG 13, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Donald R. McWilliams, M. D.				22c. DATE SIGNED 8-20-68	
22d. PHYSICIAN'S NAME (Type) Donald R. McWilliams, M. D.		22e. ADDRESS P. O. Box 248, East New Market, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Aug. 16, 1968		23c. NAME OF CEMETERY OR CREMATORY Eldorado Cemetery	
				23d. LOCATION (City or Town) (County) (State) Eldorado, Maryland	
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Maryland		ADDRESS from Frampton		25a. REC'D BY REGISTRAR DATE AUG 23 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the local health department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 11466

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
CLARENCE O. WILCOX					ESTIMATED		Aug	26	1968	M
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)	7 UNDER 1 YEAR		8 IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
Male	White	June 13, 1879		89 YRS	MONTHS DAYS		HOURS MIN.		Month	Day
7a BIRTHPLACE (State or foreign country)		7b CITIZENSHIP OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Michigan		USA				Dorchester				
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
RFD 3, Cambridge		Casons Neck, RFD 3		Wa termen		Seafood				
13a USUAL RESIDENCE (Where deceased lived, if not in hospital admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland		Dorchester		Cambridge		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Casons Neck, RFD 3		
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last	
Stephen O. Wilcox					Mary ? Arnold					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS						
No		214-34-8433A		LeCompte Funeral Service records						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion										20 Mins.
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOURS AM PM 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED
		John Mace Jr. M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				8/27/68
						ADDRESS (Street, city, town, or county)				Cambridge, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		Aug 29, 1968		Spedden-Seward Cemetery		RFD 3, Cambridge, Maryland				
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
LeCompte Funeral Service, Cambridge, Maryland				DATE AUG 30 1968		Charles Judge				





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

11467

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR M A			
Gale			Wade	Willey	Jr	August 24 1968			6 15 M			
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS		
Male		White		August 19, 1968		YRS.		5		44		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.			
Maryland		U.S.A.				Dorchester						
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Cambridge			Cambridge Md. Hospital, Inc									
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Maryland			Dorchester		Cambridge				300 Byrn Street			
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
Gale Wade Willey			Barbara Ann Todd									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17 INFORMANT			Address			
No						Mother			Toddville, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Kennel bite</u> DUE TO, OR AS A CONSEQUENCE OF <u>Prematurity, 6 mo gestation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>10 days</u> (b) <u>10 days</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>770</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING ETC			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <del>he</del> (this hospital) attended the deceased from <u>August 14, 1968</u> , to <u>August 24, 1968</u> , that <del>he</del> (we) last saw the deceased alive on <u>August 23, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) (did not) view the body after death												
22b. SIGNATURE <u>Donald Mc Williams</u>						DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>8-26-68</u>		
22d. PHYSICIAN'S NAME (Type) Dr. Donald Mc Williams						22e. ADDRESS East New Market, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			August 20, 1968			Family Plot			Toddville Dorchester Md			
24. FUNERAL DIRECTOR LeCompte Funeral Service						308 High Street Cambridge, Md.			25a. REC'D BY REGISTRAR DATE <u>SEP 10 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

1951

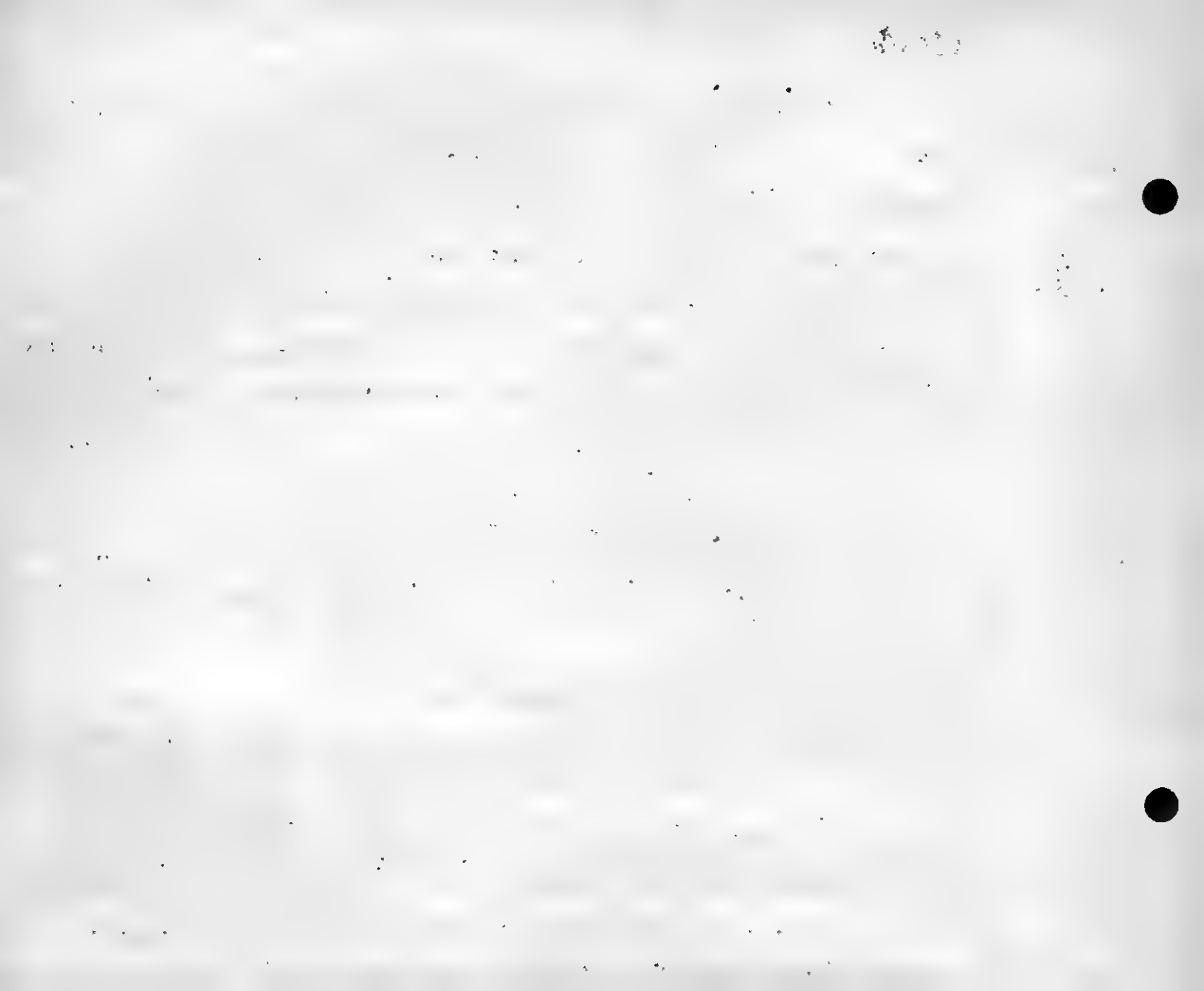


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or offending physician.

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VR A15  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
11469 CERTIFICATE OF DEATH 1176											
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
HOWARD TILDON Willey						Month Day Year Aug. 4 1968			3:30 A M		
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
MALE		White		03-24-75		93 YRS					
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		U.S. A.				Dorchester Md.					
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cambridge			EASTERN SHORE STATE HOSP			FARMER					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MD.			DOR.		Cambridge		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1207 RACE ST.		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
James Willey			Dorothy Hurley								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or <u>unknown</u> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
					MRS. J. Spedden (daughter)			Cambridge			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>As noted</u>										3 min.	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										48 hrs	
(b) <u>Cerebral Thrombosis</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>generalized arteriosclerosis.</u>										40 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>occlusion Rt femoral artery; Coronary artery insuff. myocardia</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that <del>he</del> (this hospital) attended the deceased from <u>7-26</u> , 19 <u>68</u> , to <u>8-4</u> , 19 <u>68</u> , that <del>he</del> (we) last saw the deceased alive on <u>8-4</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) ( <del>did not</del> ) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.		22c. DATE SIGNED	
<u>Donald A. Kellogg</u>				<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		8/4/68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
DONALD A. KELLOGG		EASTERN SHORE STATE HOSP.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		Aug. 6, 1968		Bucktown Churchyard		Cambridge, Md.		B.D.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
<u>Kenneth R. Thomas Jr.</u>		Cambridge Md.		DATE		<u>AUG 3 1968</u> <u>J. Charles Judge</u>					



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VR A15.4  
30M REV. 1-78

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
11469 CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or print) <b>Ralph</b>			First <b>Williams</b>			2a DATE OF DEATH Month <b>8</b> Day <b>28</b> Year <b>68</b>			2b HOUR <b>2 A M</b>			
3 SEX <b>Male</b>			4 RACE <b>white</b>			5 DATE OF BIRTH <b>08-19-03</b>			6 AGE (In years lost birthday) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	
7a BIRTHPLACE (State or foreign country) <b>Md.</b>			7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Dorchester</b> Md			
10 CITY OR TOWN OF DEATH <b>Cambridge</b>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>E.S.S.H.</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>Md.</b> COUNTY <b>Wic.</b>			13b CITY OR TOWN <b>Salisbury</b>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER <b>515 Wailes St.</b>			
14 FATHER'S NAME First <b>William August</b> Middle <b>Williams</b> Last <b>Williams</b>			15 MOTHER'S MAIDEN NAME First <b>Gertrude</b> Middle <b>Jarmine</b> Last <b>Jarmine</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b SOCIAL SECURITY NO.			17. INFORMANT Address <b>E.S.S.Hosp. Records - Cambridge</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>chronic congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized atherosclerosis with atherosclerotic undeter</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>heart disease</b> <b>Diabetes mellitus, chronic lung disease.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>		
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b> P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>8/22/1968</b> , to <b>8/28/1968</b> , that (I) (we) last saw the deceased alive on <b>8/28/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Sank Ozer</b>			DEGREE <b>FARUK OZER</b>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>8/28/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>FARUK OZER</b>			22e ADDRESS									
23a BURIAL, CREMATON, REMOVAL (Specify)			23b DATE <b>9-9-68</b>			23c NAME OF CEMETERY OR CREMATORY <b>Union Mt. Bk. Bk. Md</b>			23d LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <b>Booker M. West</b>			ADDRESS			25a. REC'D BY REGISTRAR DATE <b>SEP 11 1968</b>			25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



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1

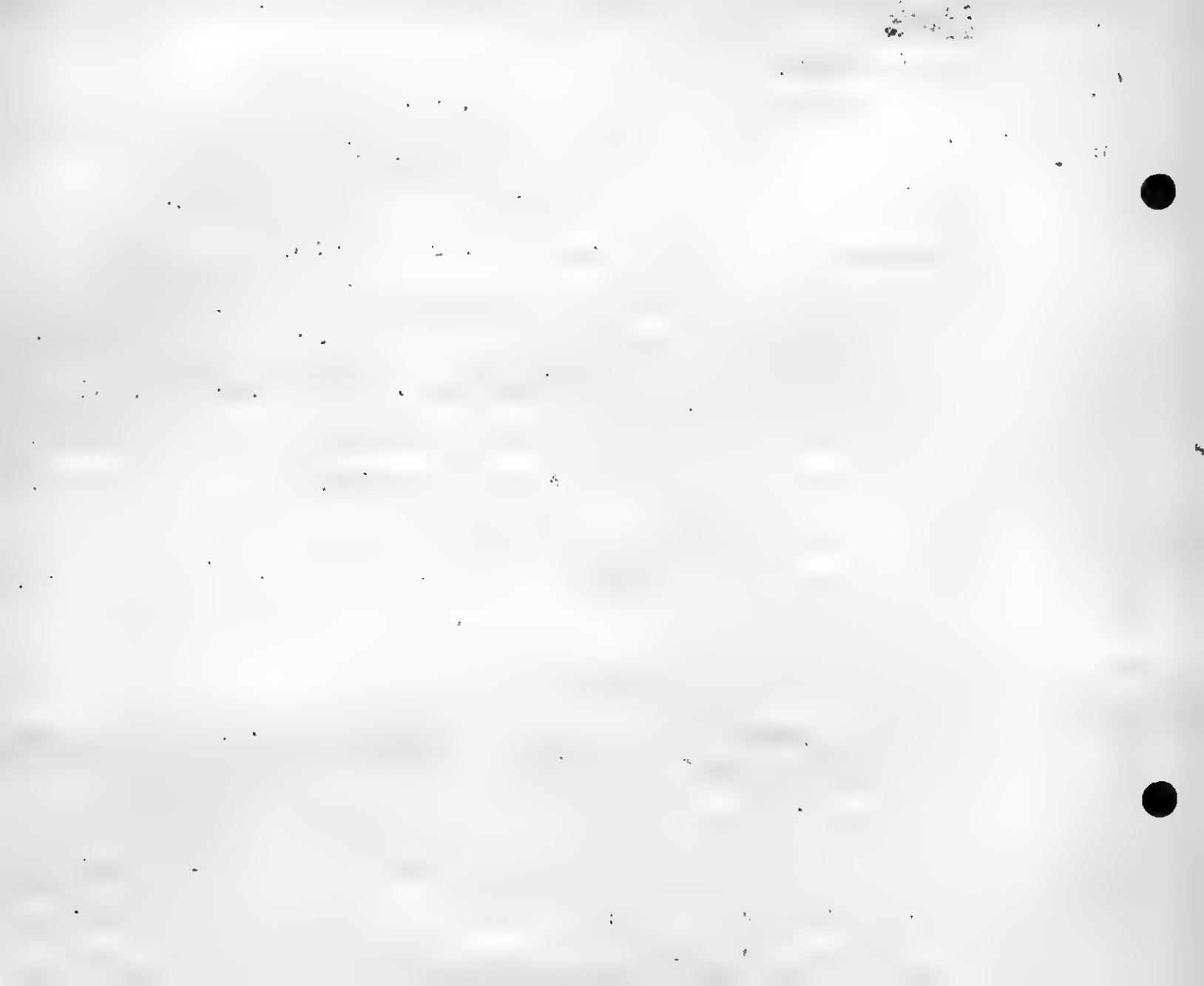
11470

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11478

1. DECEASED NAME (Type or print) First: <u>Henry</u> Middle: <u>Dudley</u> Last: <u>Wilmer</u>			2a. DATE OF DEATH 8 Month 11 Day 68 Year		2b. HOUR 11:55 P.M.
3. SEX MALE		4. RACE Negro		5. DATE OF BIRTH 8-12-98	
6. AGE (In years last birthday) 69 YRS		7. UNDER 1 YEAR MONTHS: DAYS: HOURS: M.N.		8. UNDER 24 HRS. HOURS: M.N.	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Dorchester MD.					
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eastern Shore State Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) FARMER	
12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. CITY OR TOWN TALBOT	
13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER Rt. # 1		13e. COUNTY Cordova	
14. FATHER'S NAME First: <u>John</u> Middle: <u>Wilmer</u> Last: <u>Wilmer</u>			15. MOTHER'S MAIDEN NAME First: <u>Rosa</u> Middle: <u>WARNER</u> Last: <u>WARNER</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>NO</u>		16b. SOCIAL SECURITY NO. 218 24 5696		17. INFORMANT Address: <u>Bertha Wilson Cordova, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident.</u> 4567 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Generalized Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days.</u> <u>20 yrs.</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic pneumonia, Thrombophlebitis legs, Chronic Pyelonephritis</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natlly medical examiner)			
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (the hospital) attended the deceased from <u>7-13</u> 19 <u>68</u> , to <u>8-11</u> 19 <u>68</u> , that (I) (we) lost the deceased alive on <u>8-11</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Donald A. Kellogg</u>		DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 8/11/68	
22d. PHYSICIAN'S NAME (Type) DONALD A. KELLOGG		22e. ADDRESS EASTERN SHORE STATE HOSPITAL			
23a. BURIAL, CREMAT., OR REMOVAL (Specify) Burial		23b. DATE 8/17/68		23c. NAME OF CEMETERY OR CREMATORY Newtown	
23d. LOCATION (City or Town) (County) (State) Cordova Talbot Maryland		24. FUNERAL DIRECTOR Address: <u>426 Dover Easton Md.</u>			
25a. REC'D BY REGISTRAR DATE: <u>AUG 16 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11472

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1. DECEASED-NAME (Type or Print)		First <b>WILLIS</b>	Middle <b>C.</b>	Last <b>WINDSOR, Jr.</b>	2a. DATE KNOWN OF DEATH Month <b>8</b> Day <b>12</b> Year <b>1968</b>		2b. HOUR <b>9:30 PM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Jan. 8, 1960</b>		6. AGE (In years last birthday) <b>8</b> YRS	IF UNDER 1 YEAR MONTHS _____ DAYS _____	IF UNDER 24 HRS. HOURS _____ MIN _____	2c. DATE PRONOUNCED DEAD Month <b>8</b> Day <b>12</b> Year <b>1968</b>
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Dorchester</b>	
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Cambridge Md. Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Cambridge</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First <b>Willis</b> Middle <b>C.</b> Last <b>Windsor</b>		15. MOTHER'S MAIDEN NAME First <b>Louise</b> Middle <b>?</b> Last <b>Spear</b>		13e. STREET AND NUMBER <b>Spring Drive, RFD #2</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>LeCompte Funeral Service records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple injuries, severe</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>8/12/68</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <b>9:27 PM 8/12/68</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Hit by car on Highway.</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Highway</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>US 50 Near Cambridge, Dor. Md.</b>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Mace Jr.</b>		EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>8/13/68</b>	
23a. BURNAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Aug 15, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cambridge, Maryland</b>	
24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11472

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11480

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>WILLIAM JAMES WRIGHT</b>			2a. DATE OF DEATH Month <b>August</b> Day <b>12</b> Year <b>1968</b>			2b. HOUR <b>5:30</b> P. M.			
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>January 19, 1918</b>		6. AGE (In years last birthday) <b>50</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Dorchester</b> Md.			
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Cambridge-Maryland Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Day Laborer - Canning Factory</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>		13b. <b>Dorchester</b>		13c. CITY OR TOWN <b>Hurlock</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>R.F.D. #2, Box 26</b>	
14. FATHER'S NAME First <b>Willie</b> Middle <b>Wright</b> Last <b>Wright</b>			15. MOTHER'S MAIDEN NAME First <b>Minnie</b> Middle <b>Strawberry</b> Last <b>Strawberry</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) <input checked="" type="checkbox"/> No		16b. SOCIAL SECURITY NO. <b>220-01-8168</b>		17. INFORMANT <b>Mrs. Edna Wright, Hurlock, Md., RFD #2</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pneumonitis, right lower lobe</b> <b>2509</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>2509 X</b> (b) <b>Nephritis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>Undet.</b> <b>Undet.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Alcoholism.</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from <b>8/10/68</b> , 19__, to <b>8/12/68</b> , 19__, that (I) (we) saw the deceased alive on <b>8/12/68</b> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Alfred R. Maryanov</b>				DEGREE <b>Alfred R. Maryanov, M. D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>8/19/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Alfred R. Maryanov, M. D.</b>				22e. ADDRESS <b>610 Race St., Cambridge, Maryland 21613</b>					
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>Aug. 17, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hurlock, Maryland</b>			
24. FUNERAL DIRECTOR <b>J. J. Frampton</b>				ADDRESS <b>and Son, Federalsburg, Maryland</b>		25a. REC'D BY REGISTRAR <b>AUG 22 1968</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Frampton</b>	

TO THE DIRECTOR, FBI  
FROM THE SAC, NEW YORK  
SUBJECT: [Illegible]

[The remainder of the page contains several paragraphs of extremely faint, illegible text, likely a teletype or memorandum.]

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